

## Keep Our NHS Public Briefing Paper

### Integrated care, accountable care organisations and the National Health Service (NHS)

#### Summary

*This briefing outlines how, as little as five years since the massive restructuring imposed by the Health and Social Care Act (HSC Act) of 2012, the NHS is again undergoing radical change, this time at breakneck speed and without parliamentary consent.*

Recent changes by NHS England (NHSE) divided the English NHS into 44 local health systems or 'footprints' (now 'Sustainability and Transformation Partnerships'). Each of these was required to integrate its local health services, and social care services where local authorities were willing, through cross-boundary working and pooled budgets.

These changes, relying heavily on collaboration between healthcare providers within a 'footprint', appeared to run counter to the Health and Social Care Act of 2012, which sought to promote competition.

Further changes in 2017 required ST Partnerships to deliver what was called 'accountable care' by morphing into Accountable Care Systems (ACSs), with the aim of eventually becoming Accountable Care Organisations (ACOs). ACOs are non-NHS bodies, 'designated' by NHSE, despite the absence of any statutory authority.<sup>i</sup> Behind the rhetoric of superseding competition with collaboration, NHSE intends to replace multiple smaller NHS contracts with a single, long-term lead ACO contractor for each region.

NHSE argued that introducing 'accountable care' (a term that has now been replaced by the more politically acceptable 'integrated care') is central to Government aims for the 'financial sustainability' of the NHS. In this context, 'sustainability' means reducing services to match insufficient funding. Despite being one of the richest countries in the EU, the UK currently spends less of its Gross Domestic Product (GDP) on healthcare than countries like France and Germany.<sup>ii</sup> To close the gap between these countries and the UK would require an increase in spending of over 10%.<sup>iii</sup>

In 2018, NHSE announced that Accountable Care Systems (as well as devolved health and care systems) would be renamed as Integrated Care Systems (ICSs).

#### **Integrated Care Systems and Accountable Care Organisations need to be opposed for the following reasons:**

- They are being ***introduced without adequate public involvement or meaningful consultation, and without full Parliamentary scrutiny;***
- They are being imposed in a context where ***NHS and social care services are seriously underfunded;***
- They are ***being implemented beyond any legal framework,*** creating problems of governance and accountability;
- They are being introduced at pace, with ***no robust evidence base*** to support their use in the UK context;
- ***They increase the potential scope of NHS privatisation.*** For example, with ACOs, multiple procurements will be replaced by a single, major, long-term contract to provide health and social care services for an entire area. The draft model contract for ACOs

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published by NHSE allows for, and may well attract, bids from multinational corporations.<sup>iv</sup>

- ACOs will **help strip NHS assets, such as land and buildings**, so ending the social ownership of much of the NHS estate while allowing private companies to profiteer from it.
- They will **enforce the unprecedented real terms freeze in spending** (while costs continue to rise by an estimated £22 billion<sup>v</sup> by 2020, compared with 2015 levels) and transfer the NHS's funding shortfall to new local, self-contained areas.
- Through introducing different payments systems, they **incentivise rationing of services and denial of care**, and so are fundamentally at odds with social solidarity and the values of equity and universalism that underpin the NHS;
- They **rely on unrealistic expectations**, for example about collaboration and the sharing of risk and gain between private and NHS service providers.
- They entail 'transforming' the NHS workforce; replacing experienced clinicians such as doctors and nurses with digital technologies and new, less skilled roles, such as physician and nurse associates. ACOs are **likely to under-deliver required skill levels and undermine NHS terms and conditions of employment**.

No one can deny that acute, primary care and community NHS services and social care need to be better coordinate in order to improve patient care. However, this does not require commercial contracts and the involvement of corporations.

### **A truly coordinated system of health and social care requires:**

- a) Increased funding of the NHS and personal social care;
- b) Personal social care provided on the same terms as health, free at the point of use and paid for from public funding;
- c) Full and public involvement and meaningful consultation;
- d) Robust piloting of future plans for coordination and in-depth, independent evaluation; and
- e) New legislation (see, for example, the NHS Bill 2016-17) that protects Bevan's founding principles of the NHS; ends the marketisation and fragmentation of the NHS; and re-establishes public bodies and NHS services that are accountable to Parliament and local communities.

## **'Integrated care' and the National Health Service (NHS)**

### **1. Background**

In response to the financial crisis of 2008, global consultancy firm McKinsey & Company was commissioned by the Brown government to propose strategies for cutting NHS expenditure. In 2009, McKinsey recommended a combination of provider “efficiency savings”; the ending of “low value-added healthcare interventions”; and “a shift in the management of care away from hospitals towards more cost-effective out-of-hospital alternatives”. They cited Kaiser Permanente as a US model for ‘integrated care’.<sup>vi</sup> This proposal for ‘integrated care’ (sometimes called ‘accountable care’) was further developed under the influence of the World Economic Forum (WEF).<sup>vii</sup>

The WEF initiated a project in 2012 that was ostensibly concerned with the financial sustainability of national health services. This project was steered by Simon Stevens (former advisor to Tony Blair, then executive vice president of UnitedHealth Group, a US transnational) and dominated by representatives from multinational corporations. Their report,<sup>viii</sup> co-authored with McKinsey, offered governments a number of strategies to deal with rising pressures on public health services. WEF’s preferred option was to lower costs by introducing new payment systems; reducing capacity in higher cost settings such as hospitals; and expecting individuals to provide more ‘self-care’. The report also argued that the boundaries of the health industry should be redefined, with corporations taking a greater role as markets became increasingly liberalised *and governments cut back on public services*.<sup>ix</sup>

Building on this work, the WEF ran a second project in 2013, again concerned with the ‘sustainability’ of publicly run health systems, and again with the involvement of Simon Stevens and McKinsey, among others. Their report proposed new ways of delivering integrated or accountable care based on models such as Kaiser Permanente in the US, Bundesknappschaft in Germany, the Alzira model in Spain, and “the NHS in North West London and Torbay”.<sup>x</sup>

In late 2013 Simon Stevens was appointed to take over as Chief Executive Officer for NHS England (NHSE) as of April 2014. Just six months after he took office, NHSE published its Five Year Forward View (5YFV).<sup>xi</sup> This mirrored many of the WEF’s proposals, and called for “radical new care delivery options” such as ‘Multispecialty Community Providers’ and ‘Primary and Acute Care Systems’ that NHSE likened to the Accountable Care Organisations (ACOs) emerging in Spain, the US and elsewhere.

In Spain, the Alzira model of care originated in 1999 as a private/public partnership (PPP) between Valencia’s regional government and a consortium of banks, construction firms and a private health insurer. The model was then taken up in other Spanish regions, with varying success.<sup>xii</sup> The Alzira model, at least initially, appears to have been NHSE’s preference for NHS organisations that were pioneering new care delivery systems.<sup>xiii</sup> (*For more information on the Alzira model – the exposure of its downside and its fall from grace -see Appendix One.*)

In the US, models of accountable care evolved from Health Maintenance Organisations (HMOs). HMOs, run by medical insurance groups, have been notorious for “routine denial of patients’ access to medically necessary treatment; fighting claims; screening out the sick; paying exorbitant CEO salaries; and undertaking systemic fraud”.<sup>xiv</sup> ACOs were introduced to reduce spending while improving quality measures. They also shift risk from payers (e.g. insurance companies) to providers who are paid to manage the health of populations, rather than the volume of services provided.<sup>xv</sup> Although state agencies like Medicare or Medicaid currently account for most ACO contracts, there are an increasing number of commercial ACOs in the USA, many run by insurance companies such as Aetna, UnitedHealth and Humana.<sup>xvi</sup>

From December 2015, NHSE divided the NHS in England into 44 new local health systems (first called ‘footprints’), each charged to produce a Sustainability and Transformation Plan (STP) showing how it would transform services in its area, in line with the 5YFV.<sup>xvii</sup> In 2017, each ‘footprint’ became known as a Sustainability and Transformation Partnership (ST Partnership). The idea was that eventually ST Partnerships would become full-blown Accountable Care Organisations, but given the complexity of this process, ST Partnerships were initially expected to evolve into Accountable Care Systems (ACSs).<sup>xviii</sup> In 2018, following public outcry about the inherent dangers of these new care delivery systems, NHSE renamed ACSs as Integrated Care Systems (ICSs).

### 2. What are Integrated Care Systems and Accountable Care Organisations?

Both ACOs and ICSs involve a number of service providers working together over a set period to take responsibility for the cost and quality of a specified range of health services for a defined population and for a fixed sum (a ‘whole population budget’).<sup>xix</sup> However, beyond this, there are a number of differences.

An **Integrated Care System** can take a number of forms but is, at root, an evolved version of a ST Partnership, with responsibility for the health and resources of a defined population. In theory, existing commissioning contracts remain in place. Commissioners, together with a network of providers across different services, enter into an alliance agreement and commit to agreed governance arrangements, and the sharing of risk and gain (see, for example, 3.2.5 below).<sup>xx xxii</sup>

Eight pilot or ‘shadow’ ACSs (now ICSs) were set up across England in 2017. These can affect commissioning contracts, as the Nottingham ICS shows. (*For more information, see Appendix Two.*)

In contrast, with **Accountable Care Organisations**, a single, long-term contract is held by a single organisation (in some instances a ‘care integrator’ rather than a provider - see Appendix 2) to take responsibility for providing a bundle of services. This contract holder can decide how to allocate resources and design care for the defined population, as well as change the method or point of service delivery.<sup>xxii, xxiii</sup> Given the aim of integrating health and social care services, there are concerns that the ACO may also decide which services are free and which are to be means tested.<sup>xxiv</sup>

Not all ACOs have the same structure. In one version, the lead provider is a single organisation able to set up a series of sub-contracts with other providers.<sup>xxv</sup> Alternatively, a lead provider (or group of providers) may form a new corporate vehicle (a ‘Special Purpose Vehicle’ or SPV) to hold the primary contract. The SPV is a legal entity which, in the case of PFI consortia, have been typically set up by a major bank or insurance company, and which allow the risks faced by providers to be separated out and taken on by investors looking for high financial returns.<sup>xxvi</sup> Already PFI contracts use SPVs for hospital construction and facilities management. Now ACOs can use SPVs to organise the financial administration of clinical services.

### 2.3 Lessons from elsewhere

2.3.1 In the USA, ACOs mean that the provider (not the commissioner or insurer) takes on the risk of a long-term contract to provide services for a specified population for a fixed budget based on a fee per head of population. It appears that, in the English NHS, adopting the ACO model also means the transfer of financial risk to providers.<sup>xxvii</sup> USA providers have struggled to deal with the problem of properly costing the provision of care for a population, while care coordination and information technology are proving more complicated and expensive to implement than anticipated for bodies like Medicare (See also Section 3.4.3).<sup>xxviii</sup>

By comparison, in England, funding is nowhere near the US level (in 2016, the US spent more than twice as much on health care, per capita, compared with the UK),<sup>xxxix</sup> leaving no margin for NHS organisations to deal with unexpected additional costs. The more ambitious ACOs in England also could extend well beyond health and social care services to encompass public health and other services, and so have little equivalent in the US.<sup>xxx</sup>

2.3.2 One of the best-known ACOs outside the United States is the Canterbury Health Board in New Zealand. Recent evidence suggests significant positive outcomes, such as reduced need for hospital care as a result of supporting more (particularly older) people in their homes and communities.<sup>xxxi</sup> However, in its plans for integration NHSE fails to take into account the absence in England of several important features essential to the success of the Canterbury model. These include the maintenance of acute bed numbers alongside increased investment in community-based services, and sustained investment in staff to give them the skills and confidence to innovate. Significantly, as well as investment, the Canterbury transformation has taken more than a decade while still not eradicating a substantial underlying deficit. This highlights the challenge of the tight timescales and limited funding attached to current plans for the transformation of NHS services.

### 3. What are the issues raised by integrated care systems?

#### 3.1. Human Rights issues

Proposals for integrating care are based on capitation-based payment systems, including 'integrated' or whole population budgets (WPBs) that fund services for a defined population over a specified period for fixed sum.<sup>xxxii</sup> These populations are defined according to registered patients lists, rather than by geographical area (the way in which universal care has been ensured up until now).

In addition, and even with minimum delivery standards in place, WPBs provide an inducement to raise treatment thresholds or ration some services in order to minimise costs, irrespective of the care that is actually needed.<sup>xxxiii</sup> Capitation funding has been a feature of NHS local allocations since the 1970s and today is the basis for funding of CCGs. But the WPB approach to capitation funding – especially in the absence of adequate levels of funding per capita – flouts the duty of government to care for all in society.

In these ways, introducing WPBs as the payment system to underpin integrated care potentially contravenes the NHS Constitution and is fundamentally at odds with an NHS based on the principle of social solidarity and the values of equity and universalism.

#### 3.2 Governance, accountability and legal issues

3.2.1 Simon Stevens has said that he will give ST Partnerships governance rights over organisations within their local health system, including bodies such as CCGs or local authorities with statutory responsibilities.<sup>xxxiv</sup> Currently, ST Partnerships (and the integrated care systems they may evolve into) are, by NHSE's own admission, not statutory bodies: they have no legal power to make decisions without referring these back to partner organisations.<sup>xxxv xxxvi</sup> The Conservative Party Manifesto of 2017 proposed changes by secondary legislation - without public consultation or Parliamentary scrutiny – to allow ACOs to operate and there is a danger that they may still proceed along these lines.<sup>xxxvii</sup> A recent consultation on proposed changes to the ACO model envisaged organisations that are neither NHS bodies nor local authorities having a role in both providing *and commissioning* healthcare.<sup>xxxviii</sup>

3.2.2 ST Partnerships are introducing radically new ways of delivering care with scant public involvement or any meaningful consultation. This is despite the inevitable changes these new care systems will involve, and despite current law (HSC Act 2012) and statutory guidance

requiring commissioners to directly involve the public in commissioning arrangements, <sup>xxxix</sup> including plans to transform services and proposals to change procurement and contracts.<sup>xl</sup> ACOs and ICSs are presented as local bodies working in partnership with local communities but, in reality, they will be run as businesses with little accountability to local people. This is in breach of the NHS Constitution, which commissioners have a duty to promote.<sup>xli</sup> According to the Constitution, the NHS is accountable to the public, to communities and to the patients that it serves.

### 3.3 Privatisation

3.3.1 The HSC Act 2012 gave clinical commissioning groups (CCGs) control of most funding for healthcare services at the local level. We have already said that, even though there has been no amendment of legislation so far, ACOs will transfer many of CCGs' responsibilities to potentially new organisations and these may not be NHS or local authority bodies.<sup>xlii</sup> In addition, NHSE's draft contract for ACOs shows that the contract holder could be a consortium of companies or even a Special Purpose Vehicle.<sup>xliii</sup> This could give the private sector (including multinational companies) a significant role in the planning and commissioning of services, as well in as their delivery.<sup>xliv</sup> There are some indications that ACOs will issue a 'prospectus', suggesting they intend to attract private sector funding.<sup>xlv</sup>

3.3.2 Funding to run NHS and social care services is being significantly cut.<sup>xlvi xlvi</sup> Yet the Naylor Review, to which the government appears to be committed, estimates that the infrastructure necessary for new models of care will require around £10 billion of capital investment in the medium term. The review suggests that about £2 billion of this can be raised by the sale of NHS assets, notably land and buildings owned by NHS providers in the acute sector, while facilitating the building of 26,000 new homes.<sup>xlviii</sup> Naylor observes that, currently, even though their assets might be "of greater benefit in another part of the healthcare economy", providers such as NHS Foundation Trusts tend to keep assets to fund their own interests and are unlikely to sell what they own to support others with different statutory responsibilities. However, Naylor sees that the introduction of ACOs will overcome this conflict of interest, persuading acute providers to invest their property assets in primary, community and mental health services as part of a collective responsibility within an ACO. According to the British Medical Association, land or building sales will be conducted through public/private partnerships (Project Phoenix),<sup>xlix</sup> effectively undermining the social ownership of NHS assets while allowing private companies to profiteer from these.

3.3.3 Many ST Partnerships have used private consultants (e.g. McKinsey, Deloitte and PwC) to develop plans in order to meet the requirements of NHSE's Five Year Forward View, including plans for new care delivery systems. It has been estimated that by February 2017, at least £17.6 million of NHS money had been spent on consultancy fees.<sup>l</sup>

3.3.4 Some analysts fear that new ways of delivering care, especially ACOs, will provide a structure that, in future, could help facilitate the replacement of the NHS by private health insurance.<sup>li</sup> Whilst the NHS as a whole is far too big to sell in a single transaction, ACOs will offer discrete local systems with budgets big enough to attract investors and potential takeovers, or – if the political circumstances allowed this to be considered – with organisational forms compatible with the US health insurance market.<sup>lii</sup>

### 3.4 Evidence

3.4.1 There is little robust evidence from pioneer programmes in the UK to support the introduction of ACOs or ICSs to the NHS: by NHSE's own admission, these programmes have been of short duration and provided only small sample sizes.<sup>liii</sup>

3.4.2 Ribera Salud hospitals using the Alzira model in Valencia (see Appendix One) claim to have higher patient satisfaction rates, lower staff absenteeism, shorter average lengths of patient

stay, lower waiting times and lower capitation costs than competitors. However, robust evidence is hard to find: reliable financial and contract information is limited,<sup>lv</sup> and there are serious concerns about the objectivity of data from Ribera Salud.<sup>lv</sup> Other concerns include that in 2013, after analysing data from a wide variety of public records covering 2000 – 2009, the union UGT-FSP blamed Alzira model management failures for thousands of premature deaths in one year alone.<sup>lvi</sup>

3.4.3 In the US, ACOs are still at an early stage of development but, so far, there is mixed evidence about performance.<sup>lvii</sup> <sup>lviii</sup> For example, research shows that while the majority of ACOs are able to make quality improvements, reducing costs has been more difficult.<sup>lix</sup> The majority of ACOs are in the Medicare Shared Savings Programme (MSSP), run by the Centres for Medicare and Medicaid (CMS). Claims to save money are contentious: the ACOs are in a one-sided risk-sharing scheme with the CMS, which means that ACOs can keep the savings they make, but any losses are covered by the CMS and ultimately by the US tax payer.<sup>lx</sup>

Finally, the very different contexts in which the NHS and US health care system operate (not least the different levels of funding), and the lack of a standard model of care makes it difficult to extrapolate from the US experience or learn from cross-national experience more generally. As researchers from Manchester Business School put it, “Care is needed to avoid unwarranted inferences that this [ACO] policy will deliver the claimed benefits of lower costs whilst maintaining sustainable quality.”<sup>lxi</sup>

### 3.5 Unrealistic expectations

3.5.1 ST Partnerships (and their successors, ICSs and ACOs) are expected to rely heavily on the co-operation of all their member organisations. Yet in Sept 2017, a survey showed that only one of 56 organisations involved in ST Partnerships believed that full joint working would be achieved in the next five years.<sup>lxii</sup>

3.5.2 ICSs and ACOs also have to accept a new form of financial control (a system control total),<sup>lxiii</sup> in which financial risk is shared across the whole local health system: individual providers within the system must set aside their own interests and allow any surpluses they make to be used to offset losses that have been run up elsewhere within the system. Failure to keep to the overall control total will mean no transformation funding from NHSE for the whole system. In effect, each provider will police the spending of its partners. As, increasingly, many providers within ACOs or ICSs could be private companies whose first priority must be to make profit, they are unlikely to put aside their own interests for the good of the whole, especially as some NHS providers will be in deficit.<sup>lxiv</sup> Alternatively, this system runs the risk that public funding will be used to support private companies operating at a loss.

### 3.6 Workforce issues

There are indications that one of the ways in which an ICS or ACO will reduce costs will be through ‘transforming’ its workforce. As in the McKinsey (2009) report<sup>lxv</sup> and current STP plans, “provider efficiencies” are highlighted as the biggest source of cost cutting. With staffing the biggest cost for providers, the new set ups are likely to have reduced numbers of doctors and nurses. Instead, new digital technologies will be introduced, and new roles, such as lower paid, lower skilled physician and nurse associates. It is feared that nationally agreed pay levels and NHS terms and conditions of work will be undermined as members of staff are transferred to employment by ACOs and offered locally negotiated employment contracts.<sup>lxvi</sup>

## 4. Conclusion

New systems for delivering care, like ACOs and ICSs, are being introduced at breakneck speed, without robust evidence, and in the absence of meaningful public involvement and consultation,

parliamentary scrutiny or appropriate legislation. In addition, they are already beginning to allow private corporations new roles and powers to shape the NHS in their interests.

No one can deny the need for acute, primary care and community NHS services and social care to be fully coordinated. However, this will not be achieved by fragmenting the NHS. Nor does coordination require commercial contracts and the involvement of corporates. ***The introduction of new care delivery systems such as ICSs and ACOs must be opposed.***

Instead, the success of a truly coordinated system of health and social care requires:

- ***Increased funding*** of the NHS and personal social care to ensure that coordination can deliver improved patient services rather than be the disguise for 'efficiency savings' and cuts;
- ***Personal social care provided on the same terms as health***, free at the point of use and paid for from public funding, as in Scotland;
- ***Full public involvement and meaningful consultation***;
- ***Robust piloting*** of future plans for coordination with in-depth, independent evaluation;
- ***Clarity on the governance and accountability of decision making bodies***;
- ***New legislation***, such as that drafted in the NHS Bill 2016-17, that
  - a. protects Bevan's founding principles of the NHS;
  - b. ends the marketisation and fragmentation of the NHS; and
  - c. re-establishes public bodies and NHS services that are accountable to Parliament and local communities.

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### **Appendix One: The Alzira model as the way forward for the NHS?**

The Alzira model is a form of public-private partnership (PPP), similar to the contentious Private Finance Initiative (PFI) – the dominant form of procurement for NHS projects in recent years and responsible for the current financial troubles of many NHS Trusts. Where the Alzira model differs from PFI is that not only does the private sector finance, construct and operate new public services infrastructure (such as a new hospital building), but it also runs the clinical services as well.

Under Spain's publicly funded, single-payer health system, each autonomous region administers its own care scheme. In 1997, these regions were allowed to hire private companies to manage the delivery of health care. The original Alzira PPP was set up shortly afterwards. A ten-year contract was awarded to the only bidder, UTE-Ribera (an SPV, with 51% shares held by Adeslas S.A, a medical insurance company, and other shares held by regional savings banks and health management company Ribera Salud, plus construction companies).<sup>lxvii</sup> This was to finance, build and run a new public hospital (the University Hospital of La Ribera in the town of Alzira). There was an option to extend the contract for another five years, after which the hospital would revert to government ownership.

The UTE-Ribera's tender was based on an annually adjusted capitation fee, initially set at 204 euros per resident. Health officials noted at the time that this figure was very tight. It had to cover all the expenses needed to provide the service (including payroll, drugs and other medical consumables, utilities, depreciation of assets and the cost of loans) whilst elsewhere in Valencia capitation fees were between 301 and 362 euros.<sup>lxviii</sup> UTE- Ribera's profits were capped at 7.5%.<sup>lxix</sup>

The La Ribera hospital opened in 1999. As a privately run hospital, it introduced a new contract of employment for staff not in the government tenured scheme. Terms and conditions were considerably worse than for staff in the public sector: pay scales were lower, hours were longer and there was less job security. In addition, working practices were changed to 'boost productivity'.<sup>lxx</sup> Medical salaries had a fixed component of 80% (90% for general practitioners) and a variable element (up to 20%) dependent, for example, on shifts or how staff responded to incentives.<sup>lxxi</sup>

The contract with Ute-Ribera was terminated in 2003 following financial losses. The government paid Ute-Ribera 43.3 million euros to buy the infrastructure assets, and 26 million euros in compensation for lost profit.<sup>lxxii</sup> Subsequently, and controversially, the SPV was refinanced. Ute-Ribera II paid the government a premium of 72 million euros to take over the infrastructure assets, a figure made possible for Ute-Ribera II by the government payment to its predecessor, but discouraging to other potential bidders. The capitation fee was raised to 379 euros, with generous annual increases, and the scope of the new contract was extended to include the primary care services for the local population. This gave control of patient referral to the private sector. The franchise became increasingly profitable.

Use of the Alzira model was extended to other regions, including Madrid, but only for 'specialist' or hospital-based care. However, following mass health workers' strikes and other difficulties, the regional government abandoned its plan to use the Alzira system for six public hospitals.

There has been little independent evaluation of the Alzira model. The emphasis has been on 'soft' information such as patient satisfaction surveys. Some research suggests that in 2008, compared to public health care, the Alzira model offered a saving of around 28%. This figure is highly questionable. Researchers<sup>lxxiii</sup> have noted that comparisons between PPPs and public health systems are impossible because of variation in healthcare models; lack of reliable

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information from the private sector; and because some PPP costs are still borne by the public sector. In addition, the Alzira Hospital focused on the most profitable specialisms and left caring for other patients - such as those with HIV or with complex, chronic disorders - to other hospitals. Some savings have been attributed to reduced quality of care and lower wages. Medical salaries had a fixed component of 80% (90% for general practitioners) and a variable element (up to 20%) dependent, for example, on shifts or how staff responded to incentives.<sup>lxxiv</sup> As noted above (Section 3.4.2), in 2013, research analysing data from a wide variety of public records covering the years 2000 – 2009, led the union UGT-FSP to blame the Alzira model management failures for thousands of premature deaths in one year alone.<sup>lxxv</sup>

Notably, in June 2017 the new coalition government in Valencia passed fresh legislation to return the Alzira health concession to direct public management. At around the same time the Ribera Salud Group, a main player in the Alzira PPP (and now increasingly involved in the NHS in England), came under police investigation for embezzlement and corruption.<sup>lxxvi</sup>

Also of note, Ribera Salud manages the Vinalopó University Hospital, near Alicante, via its wholly owned subsidiary, the SPV Elche Crevillente Salud SA. In Oct 2017, the Valencia regional government imposed a €150,000 fine on the SPV for exposing workers in the Pathology Department to formaldehyde, classed as “carcinogenic to humans” by the authoritative IARC.<sup>lxxvii</sup>

NHSE appears to have favoured the Alzira model but there are concerns about importing it to UK.<sup>lxxviii</sup> For example, it would transfer significant power from Clinical Commissioning Groups to private providers. In the Spanish context, commissioners used contracts to state the outcomes they wanted, but with little detail and direction about how to do this. There have also been concerns about the closeness noted between the contract holder and their suppliers, meaning less than rigorous oversight of sub-contractors. In the English context, this model could squeeze out other types of providers, like social enterprises or charitable providers. In addition, research<sup>lxxix</sup> suggests that the Alzira model has built-in ‘perverse’ incentives, such as encouraging managers to ‘cherry pick’ the most lucrative specialties or inducing clinicians to choose cheaper treatments that may not be in patients’ interest.

Ribera Salud is 50% owned by the US transnational health insurance company Centene Corporation.<sup>lxxx</sup> Centene is currently keen to expand in the UK, where they already own 75% of The Practice Group, a private company involved in providing an expanding range of NHS services, primarily in primary and community care, across a number of regions.<sup>lxxxi</sup> The involvement of Ribera Salud and Centene in the Greater Nottingham ACS is detailed in Appendix 2.

## Appendix Two

### The eight shadow Integrated Care Systems

Eight 'shadow' Accountable Care Systems (now called ICSs) were set up in early 2017. These are Frimley Health (including Slough, Surrey Heath and Aldershot), South Yorkshire & Bassetlaw (covering Barnsley, Bassetlaw, 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), and Buckinghamshire.

These shadow ICSs have been offered certain freedoms by NHSE, provided they sign up to a number of new measures, including agreeing to regional performance contracts, "assertively" reducing increases in service use, and delivering NHSE's 5YFV plans faster than other regions. Between them they have the potential to control £450 million of transformation funding over the next four years.

#### The example of Greater Nottingham 'shadow' Integrated Care System

The ST Partnership across South Nottinghamshire (the "Greater Nottingham Health and Care Partnership") is made up of four Clinical Commissioning Groups, the City and County Council, Nottingham University Hospital, Nottinghamshire Healthcare NHS Foundation Trust, Nottingham Citycare Partnership, Circle (the private hospital group that took over and then abandoned Hinchingsbrooke),<sup>lxxxii</sup> East Midlands Ambulance Service and Nottingham Emergency Medical Services.

In 2016, this Partnership began to develop a strategy for what was then termed an ACS in collaboration with McKinsey and Co<sup>lxxxiii</sup> and by drawing on the experience of three local Vanguards (i.e. pilot schemes supported by NHSE to test its proposals for new models of care). The Partnership was also working with the discredited Ribera Salud<sup>lxxxiv</sup> associated with delivering the Alzira model (See Appendix One).

By the end of 2016, the ST Partnership had submitted a proposal to NHSE concluding that three elements were required to enable integration within the ACS: a single process for commissioning health and social care services across CCGs and local authorities; joined-up delivery of health and social care services; and new partnerships to support integration, using expertise from across the UK, or internationally.

The early focus for the ACS was on Greater Nottingham and the southern part of the STP, focusing on out-of-hospital care, hospital care (including referrals and discharge processes) and urgent and emergency care.

In 2017 the Nottingham and Nottinghamshire ST Partnership used £2.7 million of its £5.7 million transformation funding to buy in interim support and advice on developing an ACS.<sup>lxxxv</sup> The ST Partnership procured commissioning support from Capita – a company infamous for what NHSE has described as an "unacceptable level of performance"<sup>lxxxvi</sup> in fulfilling a £700m contract to provide back-up services for GP practices across England that led to shortages in basic equipment and delays in the transfer of medical notes.<sup>lxxxvii</sup>

Capita is one of eight organisations accredited by NHSE to deliver support services to CCGs and other commissioners of health and social care services,<sup>lxxxviii</sup> and the only one to bid for the contract to acquire the expertise that the Greater Nottingham STP Partnership claimed was not available internally. As a prime provider, Capita supported the tender process and acted as a link between the ST Partnership and Centene UK (part of the major US healthcare insurer Centene Corporation). It is understood that Capita is to remain involved in 'assurance' work while Centene UK will be 'the boots on the ground', developing what is now an ICS and

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establishing works streams concerned with patient pathways, population health, social care, provider payment mechanisms, information management and technology and what has been described as ‘ACO design’: Centene will not be a healthcare provider but an “integrator of care”.<sup>lxxxix</sup>

A subsequent £210 million, 7-year contract for out-of-hospital care makes clear that the ICS will be a single, risk-bearing entity that manages the entire care continuum. It will hold the budget for, as well as provide, a wide range of services including Public Health, Primary Care, Community Services, Social Care, secondary Acute Care, prescribing, Mental Health and Continuing Care. Whoever wins that contract will be expected to work with the Care Integrator responsible for providing support and the successful delivery of the ICS.

Implementation of the ICS is planned for early 2018/19. The CCGs involved have already agreed to move to one contract for the ICS partnership, suggesting the system is already evolving into an ACO. From Autumn 2017 they expect to have formed a joint committee, with a single accountable officer, to oversee the work of providers and ensure value for money.

The small print of a contract notice<sup>xc</sup> appearing in the Official Journal of the EU (OJEU) indicates how the role of CCGs could change with integrated care systems. If this contract notice is anything to go by, CCGs will remain responsible for ensuring that these care systems are commissioned so as to provide maximum value; that CCGs will set the required population-level outcomes; and will hold integrated care systems to account for delivery. In turn, providers will enable the delivery of, or contracting for, provision of all NHS and local authority funded health and care services. Providers will also be responsible for integrating primary, community and hospital services. But not only this, the evolution to an integrated system will involve modification of existing providers’ contracts, and require the provider to consent to the transfer of the supervision of their contract to another provider or to the system’s Care Integrator “*in the place of the CCG*”. This is a long way from the promise made by the Minister for Health responsible for the HSC Act (2012) that CCGs would put clinicians at the heart of decision-making about health services.

## Endnotes

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- <sup>i</sup> <http://blogs.bmj.com/bmj/2017/11/14/jeremy-hunt-must-consult-properly-on-accountable-care-organisations/>
- <sup>ii</sup> A new definition of 'health spending' adopted by the Organisation for Economic Co-operation and Development (OECD) now includes spending on social care and preventative health. This definition suggests that, in 2014, the UK spent 9.8% of its GDP on healthcare compared with the average of 9.7% for the EU-15 (EU members prior to 2004). However, spending per person in the UK is below EU-15 averages. <http://www.bmj.com/content/358/bmj.j3568>
- <sup>iii</sup> <http://www.health.org.uk/blog/accounting-care-0>
- <sup>iv</sup> <https://www.england.nhs.uk/wp-content/uploads/2017/08/1bi-170804-ACO-Contract-Particulars.pdf>
- <sup>v</sup> There have not been actual cuts in total NHS funding since 2010 - funding has risen very slightly in cash terms. However, the rise has been far slower than the growth of population need and cost pressures. £22bn is the gap between the virtually frozen funding for 2015-2020 and the steadily rising costs and pressures, and that implies "savings" which must amount to cuts.
- <sup>vi</sup> <http://www.nhshistory.net/mckinsey%20report.pdf>
- <sup>vii</sup> The World Economic Forum describes itself as the International Organisation for Public-Private Cooperation, "providing a platform for the world's leading 1,000 companies to shape a better future."
- <sup>viii</sup> [http://www3.weforum.org/docs/WEF\\_HE\\_SustainabilityHealthSystems\\_Report\\_2012.pdf](http://www3.weforum.org/docs/WEF_HE_SustainabilityHealthSystems_Report_2012.pdf)
- <sup>ix</sup> For a fuller analysis of the World Economic Forum's healthcare group, and its influence on redesigning the NHS, see <https://www.sohealth.co.uk/2017/05/25/truth-stps-simon-stevens-imposed-reorganisation-designed-transnational-capitalism-englands-nhs-stewart-player/>
- <sup>x</sup> [http://www3.weforum.org/docs/WEF\\_SustainableHealthSystems\\_Report\\_2013.pdf](http://www3.weforum.org/docs/WEF_SustainableHealthSystems_Report_2013.pdf)
- <sup>xi</sup> <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>
- <sup>xii</sup> [https://www.research.manchester.ac.uk/portal/en/publications/a-comparative-policy-analysis-of-healthcare-ppps-examining-evidence-from-two-spanish-regions-from-an-international-perspective\(b6897268-4ac7-4c2a-a527-274b12324ef4\).html](https://www.research.manchester.ac.uk/portal/en/publications/a-comparative-policy-analysis-of-healthcare-ppps-examining-evidence-from-two-spanish-regions-from-an-international-perspective(b6897268-4ac7-4c2a-a527-274b12324ef4).html)
- <sup>xiii</sup> <https://www.england.nhs.uk/wp-content/uploads/2015/07/ncm-support-package.pdf>
- <sup>xiv</sup> <https://www.opendemocracy.net/ournhhs/stewart-player/accountable-care-american-import-thats-last-thing-englands-nhs-needs>
- <sup>xv</sup> <https://www.brookings.edu/wp-content/uploads/2016/06/Impact-of-Accountable-CareOrigins-052015.pdf>
- <sup>xvi</sup> <https://www.opendemocracy.net/ournhhs/stewart-player/accountable-care-american-import-thats-last-thing-englands-nhs-needs>
- <sup>xvii</sup> <https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf>
- <sup>xviii</sup> <https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf> p31
- <sup>xix</sup> <https://improvement.nhs.uk/resources/whole-population-budgets/>
- <sup>xx</sup> [https://www.england.nhs.uk/wp-content/uploads/2016/12/1693\\_DraftMCP-1a\\_A.pdf](https://www.england.nhs.uk/wp-content/uploads/2016/12/1693_DraftMCP-1a_A.pdf)
- <sup>xxi</sup> <https://www.england.nhs.uk/wp-content/uploads/2018/02/planning-guidance-18-19.pdf>
- <sup>xxii</sup> <https://www.bma.org.uk/-/media/files/pdfs/collective%20voice/policy%20research/nhs%20structure%20and%20delivery/stp/accountable-care-systems-briefing.pdf?la=en>
- <sup>xxiii</sup> [https://www.england.nhs.uk/wp-content/uploads/2016/12/1693\\_DraftMCP-1a\\_A.pdf](https://www.england.nhs.uk/wp-content/uploads/2016/12/1693_DraftMCP-1a_A.pdf)
- <sup>xxiv</sup> <http://blogs.bmj.com/bmj/2017/11/14/jeremy-hunt-must-consult-properly-on-accountable-care-organisations/>
- <sup>xxv</sup> [https://www.england.nhs.uk/wp-content/uploads/2016/12/1693\\_DraftMCP-1a\\_A.pdf](https://www.england.nhs.uk/wp-content/uploads/2016/12/1693_DraftMCP-1a_A.pdf)
- <sup>xxvi</sup> <https://peoplesbartspfi.files.wordpress.com/2016/02/pfi-nationalise-the-svps-ppl-vs-barts-pfi-version-1.pdf>
- <sup>xxvii</sup> <https://www.gponline.com/us-health-models-fit-nhs/article/1209524>
- <sup>xxviii</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4822974/>
- <sup>xxix</sup> <https://data.oecd.org/healthres/health-spending.htm>
- <sup>xxx</sup> <https://www.kingsfund.org.uk/publications/accountable-care-organisations-explained>
- <sup>xxxi</sup> [https://www.kingsfund.org.uk/sites/default/files/2017-08/Developing\\_ACSs\\_final\\_digital\\_0.pdf](https://www.kingsfund.org.uk/sites/default/files/2017-08/Developing_ACSs_final_digital_0.pdf)
- <sup>xxxii</sup> [https://www.england.nhs.uk/wp-content/uploads/2017/08/1693\\_DraftMCP-7b\\_A.pdf](https://www.england.nhs.uk/wp-content/uploads/2017/08/1693_DraftMCP-7b_A.pdf)
- <sup>xxxiii</sup> <https://www.bma.org.uk/collective-voice/policy-and-research/nhs-structure-and-delivery/models-for-paying-providers/capitation>
- <sup>xxxiv</sup> <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/public-accounts-committee/integrated-health-and-social-care/oral/48009.pdf>, Q93.
- <sup>xxxv</sup> <https://www.instituteforgovernment.org.uk/blog/sustainability-and-transformation-plans-another-nhs-reorganisation>
- <sup>xxxvi</sup> <https://www.hfma.org.uk/docs/default-source/publications/Briefings/stp-governance-briefing.pdf?sfvrsn=0>
- <sup>xxxvii</sup> <http://blogs.bmj.com/bmj/2017/11/14/jeremy-hunt-must-consult-properly-on-accountable-care-organisations/>
- <sup>xxxviii</sup> For example, Section 4 of the consultation refers to "other persons" and to arranging for the provision of NHS services. [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/643714/ACO-contract-reg-changes-consultation-1.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/643714/ACO-contract-reg-changes-consultation-1.pdf)
- <sup>xxxix</sup> <https://www.england.nhs.uk/publication/patient-and-public-participation-in-commissioning-health-and-care-statutory-guidance-for-ccgs-and-nhs-england/>

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- <sup>xi</sup> There is recent consultation on the part of the Department of Health about new regulations to facilitate the introduction of ACOs, but this is without any meaningful consultation on the introduction of ACOs themselves. <https://www.morningstaronline.co.uk/a-4cbd-We-are-citizens-and-our-voices-must-be-heard#.Wg62GRQv9f>
- <sup>xlii</sup> Health and Social Care Act (2012), Section 23.13C and Section 26.14P
- <sup>xliii</sup> <https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf> p 29, para 70
- <sup>xliiii</sup> <https://www.england.nhs.uk/wp-content/uploads/2017/08/1bii.-170804-ACO-Contract-Service-Conditions.pdf>
- <sup>xliiv</sup> <http://publicmatters.org.uk/2017/06/24/the-americanisation-of-the-nhs-happening-right-here-right-now/>
- <sup>xliv</sup> <https://www.sochealth.co.uk/2017/05/20/sustainability-transformation-plans-2/>
- <sup>xlvi</sup> <https://www.nuffieldtrust.org.uk/news-item/five-reasons-why-the-chancellor-must-find-extra-cash-for-the-nhs-at-the-budget>
- <sup>xlvii</sup> <https://www.theguardian.com/society/2017/feb/10/councils-budget-cuts-social-care-bills>
- <sup>xlviii</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/607725/Naylor\\_review.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/607725/Naylor_review.pdf)
- <sup>xlix</sup> <https://www.bma.org.uk/connecting-doctors/b/work/posts/who-ll-benefit-from-nhs-land-sell-offs>
- <sup>l</sup> <http://www.independent.co.uk/news/uk/politics/nhs-cuts-crisis-government-consultancies-millions-paid-a7640176.html>
- <sup>li</sup> <https://keepournhspublic.com/wp-content/uploads/2017/09/2017.09.06-NHS-Into-Red-Zone-final.pdf>
- <sup>lii</sup> <https://www.sochealth.co.uk/2017/05/20/sustainability-transformation-plans-2/> [see final section, The End Game]
- <sup>liii</sup> <https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf>
- <sup>liiv</sup> [https://www.research.manchester.ac.uk/portal/en/publications/a-comparative-policy-analysis-of-healthcare-ppps-examining-evidence-from-two-spanish-regions-from-an-international-perspective\(b6897268-4ac7-4c2a-a527-274b12324ef4\).html](https://www.research.manchester.ac.uk/portal/en/publications/a-comparative-policy-analysis-of-healthcare-ppps-examining-evidence-from-two-spanish-regions-from-an-international-perspective(b6897268-4ac7-4c2a-a527-274b12324ef4).html)
- <sup>lv</sup> <http://www.nottinghamnortheastccg.nhs.uk/wp-content/uploads/2015/02/SNotts-EMAHNS-SPARKLER.pdf>
- <sup>lvi</sup> <http://www.levante-emv.com/comunitat-valenciana/2013/02/21/estudio-ugt-concluye-mala-gestion-sanitaria-anticipo-muerte-2752-personas/976177.html>
- <sup>lvii</sup> <https://blogs.sph.harvard.edu/ashish-jha/2016/08/30/aco-winners-and-losers-a-quick-take/>
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- <sup>lxi</sup> [https://www.research.manchester.ac.uk/portal/en/publications/a-comparative-policy-analysis-of-healthcare-ppps-examining-evidence-from-two-spanish-regions-from-an-international-perspective\(b6897268-4ac7-4c2a-a527-274b12324ef4\).html](https://www.research.manchester.ac.uk/portal/en/publications/a-comparative-policy-analysis-of-healthcare-ppps-examining-evidence-from-two-spanish-regions-from-an-international-perspective(b6897268-4ac7-4c2a-a527-274b12324ef4).html)
- <sup>lxii</sup> <http://www.nationalhealthexecutive.com/News/almost-all-stp-bodies-reporting-poor-joint-working/183152>
- <sup>lxiii</sup> <https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf>
- <sup>lxiv</sup> <http://www.nhsconfed.org/media-centre/2017/03/nhs-england-plan-is-an-ambitious-leap-in-the-dark>
- <sup>lxv</sup> <http://www.nhshistory.net/mckinsey%20report.pdf>
- <sup>lxvi</sup> <http://www.nwlmcs.org/wp-content/uploads/2017/02/Roadshow-presentation-contract-Final.pdf>
- <sup>lxvii</sup> Ribera Salud is a health management enterprise owned by Banco Sabadell and Centene Corporation. ([http://english.riberasalud.com/wp-content/uploads/2017/03/Dossier\\_Corporativo\\_2017\\_WEB.pdf](http://english.riberasalud.com/wp-content/uploads/2017/03/Dossier_Corporativo_2017_WEB.pdf))
- <sup>lxviii</sup> <https://research.mbs.ac.uk/accounting-finance/Portals/0/docs/Spanish%20healthcare%20Public%20Private%20Partnerships%20the%20Alzira%20mode%20L.pdf>
- <sup>lxix</sup> <http://wiki.euregio3.eu/download/attachments/7209069/EUREGIO+III+Berlin+WS+The+Alzira+model+++la+ribera+case+study.pdf>
- <sup>lxx</sup> <https://research.mbs.ac.uk/accounting-finance/Portals/0/docs/Spanish%20healthcare%20Public%20Private%20Partnerships%20the%20Alzira%20mode%20L.pdf>
- <sup>lxxi</sup> <http://wiki.euregio3.eu/download/attachments/7209069/EUREGIO+III+Berlin+WS+The+Alzira+model+++la+ribera+case+study.pdf>
- <sup>lxxii</sup> <https://www.researchgate.net/publication/263378712>
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- lxxxiv [https://www.kingsfund.org.uk/sites/default/files/media/Stephen\\_Shortt\\_website%20version.pdf](https://www.kingsfund.org.uk/sites/default/files/media/Stephen_Shortt_website%20version.pdf)
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