The NHS faces bigger threats than ACOs

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One of the noteworthy features of innovation in the organisation of services in the English NHS is the enduring fascination with the United States (US) and the borrowing of ideas, models of care and terminology. At the same time, there are plenty who caution against simplistic importation from the US because of the huge differences between the two countries in almost all aspects of their approach to financing and organising services. Accountable care organisations (ACOs) and systems (ACSs) are the latest apparent imports to arrive, this time ostensibly to help integrate and 'transform' the NHS.

It seems clear that irrespective of what ACOs/ACSs are or are not achieving in the US, and what they portend for the NHS, their impact in England will be very different, partly because concepts of accountable care in England are different and partly because the existing health care system, its goals and its political accountability are so different. The other striking difference is that current initiatives at greater integration of services are not novel but have a long history in England.

ACOs/ACSs are part of a process that began in the mid-1960s – a gradual shift away from regarding the NHS as a collection of separately funded and governed institutions inherited from the early 20th century (i.e. acute hospitals, long-stay hospitals, asylums, health clinics and general practices) towards seeing the NHS as a planned system of services and care for geographically defined populations funded according to their levels of need. From this perspective, the period of the commissioner-provider split and supplier competition from 1991 until relatively recently (technically alive but strategically dead) is merely a detour. The process was given its greatest impetus by the 1974 reorganisation which, for the first time, related health care provision and funding to local populations, and shifted responsibility for community health services from local government to the new Area Health Authorities. There was even an attempt to coordinate hospital, community health services and family practitioner services better, something that remains remarkably elusive.

That ACOs/ACSs are the products of this process becomes clear when looking at their main features:

- An overarching aim related to more 'integrated care' and breaking down some of the barriers between NHS organisations (including potential mergers)
- NHS organisations (and local authorities and the Third Sector, to varying degrees), including providers and commissioners, working together (rather than competing) to meet the needs of a geographic population within a single budget

Faced with the structural weaknesses and fragmentation produced by the Health and Social Care Act 2012, and struggling with a period of extraordinary financial constraint, ACOs/ACSs can be seen as a commonsense workaround to cope with these constraints. Other commentators see ACOs/ACSs as a back-door route to the disastrous full-scale privatization of both the financing and supply of NHS

services. This is based on the possibility that local commissioners will be permitted in future by a new national ACO contract to go out to tender to procure comprehensive, integrated services for a defined population from newly formed (e.g. based on previous NHS organisations but not necessarily publicly owned) or entirely private organisations. Given the very restricted scope for making profit as a result of the falling value of NHS budgets, private providers would have to raise more money from patients in user charges. Other analysts including the King's Fund and Nuffield Trust argue the opposite - that ACOs/ACSs are likely, if anything, to reduce the amount of outsourcing of NHS services to the private sector. The Government states unequivocally that it has no intention of using these developments as camouflage to require users to pay for services that were previously free at the point of use.

Again, the arguments on both sides seem to miss the point – the principal threat to a universal service free at the point of use is much more likely to come from long-term austerity funding levels which risk pushing more and more patients to pay for their own services outside the NHS as Mark Hellowell[1] argues. He points out that there has been a big recent increase in affluent patients choosing not to wait for NHS care. While this has always happened to some degree (especially when NHS waiting times were long), if the NHS is increasingly unable to meet demands for things like elective surgery and innovative cancer treatments, it could undermine the general population's support for a tax-financed system.

The other challenge to the policy of large-scale integrated systems is whether they can achieve the transformation in care that most people accept is needed. It may be that such change will be better achieved through multiple small-scale initiatives, many of which have already demonstrated success despite having to contend with structures and policies that offer little encouragement and sometimes even obstructions. As ACOs/ACSs develop, it will be vital that they support and facilitate the creativity and entrepreneurship of the myriad of health and social care staff and patients who can and want to change the face of services.

1. Hellowell M. How the NHS will die – in the explosion of "self-pay" procedures, we are witnessing the beginning of the end. *Prospect* February 2018: 6