Keep Our NHS Public Briefing Paper

Accountable care systems 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.

Whereas the HSC Act increased competition, recent changes introduced by the quango NHS England (NHSE) appear to do the opposite. NHSE first divided the English NHS into 44 local health systems or 'footprints' (now 'Sustainability and Transformation Partnerships') and required each of these to integrate its local health and social care services through cross-boundary working and pooled budgets. Now, from 2017, these Partnerships are required to deliver 'accountable care' by morphing into Accountable Care Systems (ACSs), with the aim of eventually becoming Accountable Care Organisations (ACOs).

NHSE argues that introducing 'accountable care' (also called 'integrated care' in some contexts) is central to ensuring 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 below EU average levels on healthcare.[i]

Accountable care systems (i.e. both ACOs and ACSs) need to be resisted for the following reasons:

- They are being **introduced at breakneck speed, without adequate public involvement or consultation**;
- They are **being implemented beyond any legal framework**, creating problems of governance and accountability;
- They have **no robust evidence base** to support their use in the UK context;
- They will **help strip NHS assets, such as land and buildings**, so ending the social ownership of much of the NHS estate and transferring it to private ownership.
- They will apply **unprecedented cuts in spending** (£22 billion[ii] by 2020, compared with 2015 levels) and transfer the NHS's funding shortfall to new local, self-contained areas.
- They **incentivise rationing of services** and so are fundamentally at odds with social solidarity and the values of equity and universalism that underpin the NHS;
- They **increase the potential scope of NHS privatisation**. For example, 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 published by NHSE allows for, and is likely to attract, bids from multinational corporations.[iii]
- They **rely on unrealistic expectations**, for example about collaboration and risk -sharing between private and NHS providers.
- They entail 'transforming' the NHS workforce, replacing experienced clinicians with technologies, and introducing new roles, such as lower paid, lower skilled physician and nurse associates. ACOs are **likely to undermine NHS terms and conditions of employment.**

No reasonable person could argue against the need for better integration of social care services and NHS acute, primary and community care. However, in reality, NHSE's current programme for integrated or 'accountable care' will fragment the NHS. It is against the interests of patients and in favour of the private healthcare industry, and – shockingly – is taking place without proper Parliamentary scrutiny.

Given the current context, accountable care systems must be opposed. Changing the context requires increased funding, as well as new legislation (such as the NHS Reinstatement Bill) that protects the founding principles of the NHS, ends its marketisation, and re-establishes NHS public bodies and services that are accountable to Parliament and local communities. The roll-out of accountable care systems is taking place without robust piloting and evaluation, and without full public involvement and consultation. ***It should be halted.***

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, they 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'.[iv] ***This move to accountable then developed under the influence of the World Economic Forum (WEF).***[v] This body initiated a project in 2012, 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 ostensibly concerned with the financial sustainability of national health services. The WEF report,[vi] co-authored by 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.[vii]

Building on this work, ***the WEF ran a second project in 2013, again concerned with the 'sustainability' of 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 and the Alzira model in Spain.[viii]

In late 2013 Simon Stevens was appointed to take over as Chief Executive Officer for NHS England (NHSE) from April 2014. Six months after he took office, NHSE published its *Five Year Forward View* (5YFV)[ix]. This ***echoed many of the WEF's proposals, including the need for "radical new care delivery options" that NHSE likened to the Accountable Care Organisations (ACOs)*** emerging in Spain, the US and elsewhere.[x]

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.[xi] The Alzira model appears to be NHSE's preference for NHS organisations that are pioneering new care delivery systems.[xii] (***For more information on the Alzira model - and its fall from grace -see Appendix One***).

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". The insurance industry – companies like Aetna, UnitedHealth, Humana and Blue Cross - are now taking a leading role in developing the ACO model in the UK.[xiii]

From December 2015, the NHS in England was divided into 44 new local health systems ('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.[xiv] Then, in 2017, each 'footprint' became a Sustainability and Transformation Partnership (ST Partnership). The idea is that eventually ST Partnerships will become full-blown Accountable Care Organisations, but given the complexity of this process, ST Partnerships are initially expected to evolve into Accountable Care Systems (ACSs).[xv]

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

The terms ACO and ACS are often used interchangeably but there is a distinction. Both 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').[xvi] However, beyond this, there are a number of differences.

2.1 ***An Accountable Care System is 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 managing resources together, along with agreeing governance arrangements and the sharing of risk and gain.[xvii] Eight pilot or 'shadow' ACSs were set up across England in 2017. They are not benign, and can affect commissioning contracts, as the Nottingham ACS shows. (***For more information, see Appendix Two***.)

2.2 ***In contrast, with Accountable Care Organisations, there is a single, long-term contract that establishes a lead provider (or 'integrator') to take responsibility for providing a bundle of services***. This integrator can decide how to allocate resources and design care for the defined population, as well as change the method or point of service delivery.[xviii, xix]

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.[xx] ***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, typically set up by a major bank or insurance company, which allows the risks faced by providers to be separated out and taken on by investors looking for high financial returns.[xxi] PFI contracts use SPVs for hospital construction and facilities management. ACOs can use them for 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 specific services for a specified population for a fixed, capitated budget (i.e. based on a fee per head of population). ***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).[xxii]

By comparison, in England, funding is nowhere near the US level (nearly 20% of the US gross domestic product is spent on healthcare)[xxiii] and so there is no margin for organisations to deal with unexpected additional costs. The more ambitious ACOs in England also extend well beyond health and social care services to encompass public health and other services.[xxiv]

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 reducing the need for hospital care by supporting more (particularly older) people in their homes and communities.[xxv] However, in its plans for accountable care systems, NHSE fails to take into account several ***important features essential to the success of the Canterbury model.*** These ***include 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***, highlighting the challenge of the tight timescales and limited funding attached to current plans for transformation of NHS services.

3. What are the issues raised by accountable care systems?

3.1. Human Rights issues

The introduction of accountable care is largely driven by NHSE's commitment to 'efficiency savings'. Accountable care systems are based on new payment systems including ***whole population budgets*** (WPBs) to provide services to a defined population for a fixed sum. Even with minimum delivery standards in place, WPBs ***provide an inducement to raise treatment thresholds in order to minimise costs, irrespective of the care that is actually needed***.[xxvi] This approach flouts the duty of government to care for all in society and contravenes the NHS Constitution. It 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 made it clear 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.***[xxvii] However, unless Parliament legislates to change their status, ST Partnerships (and the accountable 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***.[xxviii] [xxix]

3.2.3 ST Partnerships are introducing accountable care systems with ***scant public involvement or consultation***, despite the changes in service provision that are inevitably involved. ACOs and ACSs 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's principle that 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. Now, even though there has been no

amendment to legislation, ACOs will transfer many of CCGs' responsibilities to new lead providers.[xxx] NHSE's draft contract for ACOs shows that, potentially, the lead provider can be a consortium of companies or even a Special Purpose Vehicle,[xxxi] giving the private sector (including multinational companies) ***a significant role in the planning and commissioning of services, as well in as their delivery***.[xxxii]

3.3.2 It has been estimated that the infrastructure necessary for ***new models of care will require around £10 billion of capital investment*** in the medium term. The suggestion is 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.[xxxiii] However, ***ST Partnerships may only have access to and sell these assets if the purchasers and providers in the system become a single organisation - in other words, an ACO***. (With ACSs, land remains in the ownership of providers.) Therefore, ***ACOs could provide a means of ending social ownership of NHS assets and transferring these to private ownership***.

3.3.3 Some fear that accountable care models will provide a structure that, in future, could help facilitate the replacement of the NHS by private health insurance.[xxxiv] Whilst the NHS as a whole is far too big to sell in a single transaction, ACOs will offer discrete local systems with budgets small enough to attract investment and potential takeover, and with organisational forms compatible with the US health insurance market. [xxxv]

3.4 Evidence:

3.4.1 There is little robust evidence from pioneer programmes in the UK to support the introduction of accountable care systems to the NHS: by NHSE's own admission, these programmes have been of short duration and provided only small sample sizes.[xxxvi]

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 numbers, shorter average lengths of stay, lower waiting times and lower capitation costs than competitors. However, ***robust evidence is hard to find***: reliable financial and contract information is limited,[xxxvii] and there are concerns about the objectivity of data from Ribera Salud.[xxxviii] 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.[xxxix]

3.4.3 ***In the US, ACOs are still at an early stage of development but, so far, there is mixed evidence about performance***.[xl] [xli] For example, research shows that while the majority of ACOs are able to make quality improvements, reducing costs has been more difficult.[xlii] 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.[xliii]

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."[xliv]

3.5 Unrealistic expectations

3.5.1 ST Partnerships (or subsequently accountable care systems) will have to rely heavily on the co-operation of all organisations within each partnership. Yet according to a survey published in Sept 2017, ***only one of 56 ST Partnerships is achieving effective joint working between local government and health organisations***.[xlv]

3.5.2 ST partnerships and their successors also have to introduce a new form of financial control (a shared control total),[xlvi] 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 elsewhere within the system. In effect, ***each provider will police the spending of its partners. As, increasingly, many providers within an accountable care system will 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***.[xlvii] Alternatively, this system runs the risk that public funding will support private companies operating at a loss.

3.6 Workforce issues

There are indications that one of the ways in which ACOs will reduce costs will be through 'transforming' its workforce. As in the McKinsey 2009 report and current STP plans, "provider efficiencies" are the biggest source of cost cutting. ***ACOs are likely to have reduced numbers of doctors and nurses who will be replaced by new technologies and new roles, such as lower paid, lower skilled physician and nurse associates. It is expected 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.

4. Conclusion

No one can deny the need for acute, primary care and community NHS services and social care to be more integrated. Whether accountable care systems can achieve this is unclear: there is little to no robust evidence that they will provide better integration, especially in the context of a seriously underfunded NHS. What is clear is that despite the lack of evidence, accountable care systems are being introduced at breakneck speed, and in the absence of public involvement and consultation, parliamentary scrutiny or appropriate legislation. In addition, accountable care systems, in the current context, facilitate increasing privatisation of the NHS, giving private corporations new roles and powers to shape the NHS in their interests.

These new models of care should be opposed unless the evidence for and against the models is examined, and the context in which these systems operate is fundamentally changed. This means new legislation, such as the NHS Reinstatement Bill, that protects the 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.

Even then, with the private sector excluded, the introduction of accountable care systems should be halted unless there is

a) ***full public involvement and consultation***;
b) ***robust piloting and in-depth, independent evaluation***; and

c) ***increased funding of the NHS*** (e.g. to average EU levels) to ensure new models of care aim to improve patient services rather than make 'efficiency savings' and cuts.

Jan Savage, Tower Hamlets KONP, with thanks to Greg Dropkin, and to KONP members for their comments.

Appendix One: The Alzira model

The Alzira model is a form of public-private partnership (PPP), similar to the contentious Private Finance Initiative (PFI). However, in addition to the private sector financing, constructing and maintaining new infrastructure (such as new premises), with the Alzira model the PPP is also responsible for the delivery of all associated health services, and potentially non-clinical support services as well.

The original Alzira PPP marked the first time that the private sector in Spain could enter into contracts to self-manage hospitals. The model was based on a partnership between the regional government of Valencia and UTE Ribera - a consortium of banks, construction firms and a private health insurance company, similar to the Special Purpose Vehicles in PFI contracts. The Valencia government, then led by the People's Party (conservative Christian Democrats), granted this consortium a 15 year 'management concession' to provide the region of Alzira with primary and specialist health care, integrated with the existing Spanish NHS. The contract was to design and build a new 300-bed hospital and operate a district network comprised of the hospital plus four integrated health centres and 46 primary care centres, delivering clinical and non-clinical services for the 250,000 residents of the Alzira district. (Use of the model was later extended to other regions, including Madrid.)

A central feature of this model was a 'payment by capitation' system. Under the contract, the government of Valencia paid UTE Ribera an annually adjusted fee for each resident for the duration of the contract. This figure 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. UTE Ribera profits were capped at 7.5%.

Hospital doctors and many GPs working within the Alzira model were not employed by the public sector, as was usual in Spain's public hospitals, but by the operating company. Generally, in Spain, private sector contracts of employment have worse terms and conditions, including less job security, lower pay scales and longer working hours, allowing increases in productivity of around 20 – 30% compared to the public sector. In Alzira, medical salaries had a fixed component (80%) and a variable element dependent, for example, on how staff responded to incentives. The unified information system for sharing patients' data not only made patient costs visible to clinicians, it allowed individual clinicians' work to be monitored. In Madrid, following mass health workers' strikes and other difficulties, the regional government abandoned its plan to use the Alzira system for six public hospitals.

While NHSE clearly favours the Alzira model and some of its features – like better integration of care - would be welcome in the NHS, there have been concerns about importing it to UK.[xlviii] For example, it would transfer significant power from Clinical Commissioning Groups to private providers. Not least, with the Alzira model, commissioners use contracts to state the outcomes they want, 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. This model could squeeze out other types of providers like social enterprises or charitable providers. In addition, research[xlix] 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.

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.[l]

Notably, in June 2017 the new coalition government in Valencia passed new 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 involved in the NHS) – came under police investigation for embezzlement and corruption.[li] Ribera Salud is 50% owned by the US transnational health insurance company Centene Corporation.[lii] 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.[liii] Their involvement in the Nottingham ACS is detailed in Appendix 2.

Appendix Two

The eight shadow Accountable Care Systems

Eight 'shadow' Accountable Care Systems 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 ACSs 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 growth 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' Accountable 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 Hinchingbrooke),[1] East Midlands Ambulance Service and Nottingham Emergency Medical Services.

In 2016, this Partnership began to develop a strategy for an ACS in collaboration with McKinsey and Co[2] 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[3] 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 Accountable Care System (ACS).[4] The ST Partnership procured commissioning support from Capita – a company infamous for what NHSE has described as an

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1 https://www.parliament.uk/business/committees/committees-a-z/commons-select/public-accounts-committee/news/report-circle-withdrawal-from-hinchingbrooke-hospital/

2 http://www.nottinghamshire.gov.uk/media/125380/stp-spend-on-management-consultancy-ncc-026868-17.pdf

3 https://www.kingsfund.org.uk/sites/default/files/media/Stephen_Shortt_website%20version.pdf

4 http://www.nottinghamshire.gov.uk/media/127084/ncc-027236-17.pdf

"unacceptable level of performance"[5] in fulfilling a £700m contract to provide back-up services for GP practices across England, leading to shortages in basic equipment and delays in the transfer of medical notes.[6]
Capita is one of eight accredited 'prime providers'[7] on the NHS Lead Provider Framework run by NHSE, 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 will remain involved in 'assurance' work while Centene UK will be 'the boots on the ground', developing the ACS and specialising in the integration of systems and pathways – it will not be a healthcare provider. (BMA)

So far, Centene UK has been involved in establishing work streams to identify the next steps necessary for setting up an ACS. These work streams are concerned with patient pathways, population health, social care, provider payment mechanisms, information management and technology and what has been described as 'ACO design'.

A subsequent £210 million, 7-year contract for out-of-hospital care[8] makes clear that the ACS 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 the contract will be expected to work with a Care Integrator[9] – possibly a private company or consortium - responsible for providing support and the successful delivery of the ACS.

Implementation of the ACS is planned for early 2018/19. The CCGs involved have already agreed to move to one contract for the ACS partnership. 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 the out-of hospital contract indicates how the role of CCGs is expected to change. They will remain responsible for ensuring that the ACS is commissioned so as to provide maximum value; sets the required population-level outcomes; and holds the ACS 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 ACS will involve modification of the existing provider's contract, and require them 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".*

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5 http://www.nationalhealthexecutive.com/News/capita-primary-care-service-performance-still-unacceptable-nhs-england-admits/150204

6 https://www.bma.org.uk/news/2017/august/outsourcing-firm-and-us-healthcare-insurer-team-up-to-run-stp?imgdoctors

7 ***"A prime provider would typically receive a capitated budget to provide all care specified in the contract. The prime provider would also use this budget to 'buy' additional services (through sub-contracts) that it cannot deliver directly."***
https://www.kingsfund.org.uk/publications/commissioning-contracting-integrated-care/summary

8 http://ted.europa.eu/udl?uri=TED:NOTICE:338580-2017:TEXT:EN:HTML&src=0

9 For a diagram showing where the Care Integrator fits in the ACS, see https://www.kingsfund.org.uk/sites/default/files/media/Stephen_Shortt_website%20version.pdf

Endnotes

i https://www.kingsfund.org.uk/blog/2016/01/how-does-nhs-spending-compare-health-spending-internationally

ii 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 2015-2020 and the steadily rising costs and pressures, and that implies "savings" which must amount to cuts.

iii https://www.england.nhs.uk/wp-content/uploads/2017/08/1bi.-170804-ACO-Contract-Particulars.pdf

iv http://www.nhshistory.net/mckinsey%20report.pdf

vThe 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."

vi http://www3.weforum.org/docs/WEF_HE_SustainabilityHealthSystems_Report_2012.pdf

viiFor a fuller analysis of the World Economic Forum's healthcare group, and its influence on redesigning the NHS, see https://www.sochealth.co.uk/2017/05/25/truth-stps-simon-stevens-imposed-reorganisation-designed-transnational-capitalism-englands-nhs-stewart-player/

viii http://www3.weforum.org/docs/WEF_SustainableHealthSystems_Report_2013.pdf

ixhttps://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

x Early models for providing accountable care in the English NHS were referred to in the 5YFV as 'Multispecialty Community Provider' (MCP) and 'Primary and Acute Care Systems' (PACS).

xi 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

xii https://www.england.nhs.uk/wp-content/uploads/2015/07/ncm-support-package.pdf

xiii https://www.opendemocracy.net/ournhs/stewart-player/accountable-care-american-import-thats-last-thing-englands-nhs-needs

xiv https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

xv https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf p31

xvi https://improvement.nhs.uk/resources/whole-population-budgets/

xvii https://www.england.nhs.uk/wp-content/uploads/2016/12/1693_DraftMCP-1a_A.pdf

xviii https://www.bma.org.uk/-/media/files/pdfs/.../accountable-care-systems-briefing.pdf?

xix https://www.england.nhs.uk/wp-content/uploads/2016/12/1693_DraftMCP-1a_A.pdf

xx https://www.england.nhs.uk/wp-content/uploads/2016/12/1693_DraftMCP-1a_A.pdf

xxi https://peoplevsbartspfi.files.wordpress.com/2016/02/pfi-nationalise-the-spvs-pple-vs-barts-pfi-version-1.pdf

xxii https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4822974/

xxiii www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html

xxiv https://www.kingsfund.org.uk/publications/accountable-care-organisations-explained

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