The conundrum of accountable care organisations explained

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ABSTRACT

This is the final in a series of three articles that explains integrated care and explores its impact on NHS England. This article unearths the controversial debate about accountable care organisations. Their planned introduction has resulted in judicial reviews and has called into question the principles that underpin the NHS. The article begins with an outline of the concept of accountable care organisations, and the controversy that has been stirred up by proposals for their launch. The article then explores three issues that are behind this controversy. The first is the role of government, and how the latest phase of public policy is reshaping government's role in society and the delivery of health and social care. The second is the debate between 'make or buy', and how the pendulum is swinging between in-house provision and contracting out. The final issue is the is exploration of value in healthcare, and how the outcome focus that is integral to integrated care will have an impact on the role of accountable care organisations. The article concludes with the themes from the three articles that will shape the implementation of integrated care and accountable care organisations.

Key Words: Accountable care organisations ■ Integrated care ■ Leadership ■ System

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Integrated care will take a lot of time and effort to establish itself. Even if it is legislated – which is highly unlikely until after the next election – integrated care is a cultural change that will have to displace vested interests. These interests of the established order – managerial, clinical, governmental – will push back against the new order.

The growing impetus behind integrated working, such as financial meltdown and patient and public expectations, means that there is an inevitability behind integrated care, but this does not make it any easier to implement.

It also does not help that there is a disconnect at regulator level. The latest planning guidance for Trusts from NHS Improvement (Dalton, 2018) does not even mention system working or integrated care. Trusts are not islands in their Sustainability and transformation plans (STPs), but they are being performance managed as if they are. However, there is hope from experience on the ground – some healthcare leaders are working through system integration collectively, and supporting their peers who find system working a challenge too far.

Into this environment accountable care organisations (ACOs) have been introduced – not yet re-packaged in the new 'integrated care' brand. This new model comes with considerable baggage and has stirred up further controversy about privatisation in the NHS. To lever change in the NHS, the concept of 'any willing provider' (AWP) was introduced by the Labour government in 2009, to then be re-framed as 'any qualified provider' (AQP) by the Coalition government. With ACOs on the horizon, those seeking to protect the NHS from the perceived encroachment of the private sector

saw the need to mount defences, hence the two judicial reviews brought by the Twitter hashtag JR4NHS, and 999 Call for the NHS (2018) around the proposed contract for accountable care organisations.

There is considerable complexity, ambiguity and controversy behind the ACO concept. What this article does is provide the framework within which a meaningful ACO debate can take place. The article explores three components of this framework: first, the role of government in the provision of public services; second, the debate about 'make or buy' decisions in the delivery of public services; third, the concept of value in healthcare and what this means for an ACO. The article concludes with a balcony view of the impact of these issues on the introduction of ACOs, and the challenge for leaders in meeting conflicting expectations. But first, a recap on the concept of the ACO.

Accountable care organisations

The concept of ACOs is an American import. In itself, this gives impetus to the campaign groups seeking to save the NHS from what they regard as privatisation. The idea behind an ACO is that it can bid for contracts to provide NHS services. The Five Year Forward View (NHS England, 2014) models of multispecialty community provider, primary care at home, and primary and acute care systems are all precursors to ACOs.

Like an integrated care system, an ACO will work with a capitated budget; therefore, it will have an incentive to focus on population health. As demand increases it will need to make decisions about the allocation of resources and delivery of services that could limit access and enable the ACO to keep within budget. If it does come in under budget, then the surplus can be retained. This is another criticism of the ACO concept, namely potentially making money from the NHS.

In contrast to the fluid governance nature of an integrated care system, an ACO will have a formal governance and organisation structure behind it. An ACO could take many forms, but to go upstream to population health, a broad range of community and social care groups would need to be involved, adding further complexity to its governance. An ACO could be from within the NHS family, a social enterprise or a private company. It will also have contracts with the NHS, and it is the draft ACO contract currently under consultation (NHS England, 2017) that has added to the controversy. An ACO will therefore put 'organisation' into integrated/accountable care, but the sheer complexity of the outcome-based challenge and the governance required will make it difficult for this type of organisation to become established.

ACOs will not be the first organisations to have contracts with the NHS. From the outset of the service 70 years ago, general practices as small private sector businesses have been contacted to provide services to the NHS – they account for 90% of NHS activity (NHS England, 2014), but only 8% of NHS expenditure. Through waiting list initiatives, private hospitals have been commissioned to provide surgical services, and then Independent Sector Treatment Centres (Department of Health, 2000) were commissioned and built to increase capacity further. Now, under AQP, many specialist and core services are contracted out to the private sector and social enterprise companies.

Health care provision through the NHS is an emotive subject. It was Nigel Lawson who observed that 'The National Health Service is the closest thing the English have to a religion' (Lawson, 1992). The opening ceremony of the London 2012 projected this connection to the world.

Role of government

The premise of these articles is that the NHS has moved from the post-war era of the welfare state, through the Thatcherite competitive market, to a new age of civic good, which is shaping the way in which public policy is being determined and executed. Civic good combines a number of discernible trends:

- Less reliance on the market as the means for the delivery of public services
- Enhanced role for recipients of public services to shape its delivery
- Greater fairness in how society treats its citizens

- Providers of public services working in more integrated and collaborative ways
- Maximising the public sector pound through the lowering of funding barriers
- Blurring professional boundaries so service providers see the whole person
- Going upstream to population health to reshape demand for public services
- Greater focus on the public to take responsibility for their health and well being
- Building resilience in communities to enable members of the public to achieve their potential
- Being smart with information and technology to leverage this change.

These trends are neither new nor will they produce immediate results. What civic good does is to provide the narrative that enables these individual policies to deliver collective impact. The re-framing of the immigration debate and the move away from a 'hostile environment' (Hill, 2017) is the most recent example of this trend. In considering public policy in this era of civic good, we need to reflect on the role of government.

To what extent do governmental institutions help or hinder citizens? John McKnight (1995: 168) observed that 'As institutions gain power, communities lose their potency and the consent of community is replaced by control of systems; the care of community is replaced by the service of systems; the citizens of community are replaced by the clients and consumers of institutional products'. This was the position that Grenfell residents found themselves in. But this does not mean a withdrawal of government services; rather, a need to empower the public.

However, some citizens need more support than others to become what David Brooks (2011: 322) calls 'social animals'. Some citizens have less opportunity and more obstacles in life, so Brooks proffers a role for government: 'Government should not run people's lives. That only weakens the responsibility and virtue of the citizens. Government could influence the setting in which lives are lived. Government could, to some extent, nurture settings that serve as nurseries for fraternal relationships. It could influence the spirit of the citizenry'.

> "Integrated care should be the ideal means to deliver value, through viewing the whole patient"

Brooks projects a defined, yet interventionist, role for the government. As this role takes shape, we are seeing more of government 'push' in place of 'nudge' (Thaler and Sunstein, 2009: 6). This is appearing in areas of policy and legislation around smoking, unit pricing for alcohol, use of plastic bags, betting, sugar tax, banning of single use plastics, and use of diesel fuel. While there is still a role for nudging members of the public in the right direction, we are seeing more examples of compulsion being exercised by the state on the public's behalf. This is not a return to the 'nanny state', but rather a rebalancing of citizen rights and responsibilities.

Government should, therefore, invest for the long-term in social capital, and not just infrastructure. But will the government contract out some of its responsibilities?

Make or buy

The make or buy dilemma is at the heart of the controversy surrounding ACOs. The pendulum has swung on privatisation over the 70 years of the NHS – nationalisation post-war, then the sell-off beginning in the 1980s that continues today. With the introduction of competition into public services in the 1980s, local government was forced to undertake 'compulsory competitive tendering', which then morphed into 'best value' when Labour came to power. The idea was to test the market to get the best price and quality of provision. The Choice agenda introduced in 2006 under Labour then widened competition, not just among public institutions, but with private providers also encouraged to tender. Over recent years, some commissioners have interpreted regulations governing the trade in services to encourage the market testing of core health and social care services.

The rationale behind the 'make or buy' decision in public services was shaped by the 'reinventing government' movement (Osborne and Gaebler, 1992), stating that government

should 'steer more than they row'. This thought influenced the way in which the NHS commissioned and supplied services in the following 25 years.

Contracting out has become an industry of its own. The House of Commons Committee on Public Accounts (2014) estimated that half of government spending on goods and services is on contracting out with only four main suppliers, which 'has led to the evolution of privately-owned public monopolies'. The recent collapse of Carillion highlighted the exposure of the public sector to these major suppliers. The criticism of ACOs is that they might get into a similar position as a local monopoly supplier.

While the transaction costs for buying services in the NHS do not rival those of the USA, the criticism is that resources are diverted away from healthcare provision for questionable gain. Also, the contracting process still shows signs of immaturity. For example, when two Lancashire NHS Trusts brought a legal case when they lost a contract to the private sector, the High Court judge ruled that the commissioner did not include in the criteria the 'considerable cost and disruption' of service change (Matthews-King, 2018).

While the intent of government in its approach to contracting is to get better services for less cost, it is not just in healthcare that problems emerge. In rail franchising, the irony is that foreign governments are operating 72% of UK rail franchises (Javed, 2018). Critics observe that it was not meant to be like this. As James Meek (2015) states, 'The most absurd paradox of Britain's privatisation is that it has led to the nationalisation of British infrastructure by foreign governments'.

This is the environment in which ACOs will be bidding for NHS services. They will need to demonstrate real added value in what should be outcome-based contracts, and this in itself could limit the range of providers that will be interested in tendering.

Value in healthcare

Public services are too often measured by the resources invested, rather than the outcome gained. The NHS Plan (Department of Health and Social Care, 2000) is a prime example of this. The same can be said for access targets, such as the A&E 4-hour wait and 18-week treatment targets. Of course, nobody wants to wait, but input measures need to be balanced with outcome achieved and the overall value added.

The zero-sum of competition identified by Michael Porter (2004) has been responsible for a range of value-eroding behaviours, such as: shifting costs between commissioner and provider; increasing volume to earn income; and enhancing specialisation of services to earn income. Competition has resulted in win-lose actions carried out by supposedly altruistic public servants. In contrast, as Nancy Kline (1999: 73) observed, 'When people are not competing with each other to be best, it is possible to think all the way to something good'.

The 'something good' is to put value into healthcare, since competition is not focused on delivering value for patients. Porter (2010) defines value as 'health outcomes achieved per dollar spent'. The fragmented nature of the patient journey, characterised by silos of care each seeking to offer its own value, means that real value is divided when it should be increased. The result is that competition delivers zero-sum healthcare and contributes to unacceptable results: too many preventable errors in diagnosis and treatment; low or variable quality; under- or over-treatment; and waste or duplication of resources.

ACOs will be operating in this new era of civic good where Porter's interpretation of value in healthcare prevails. Integrated care should be the ideal means to deliver value, through viewing the whole patient, going upstream to work on prevention, and thinking and acting 'system' rather than 'organisation'. Indeed, integrated care can only succeed if this approach is taken. ACOs will therefore need to operate in this way so they can meet both their capitation and commissioner requirements.

For these reasons, ACOs from the private sector will find it challenging to compete in the new integrated care environment. This can be viewed from the commissioner and ACO perspectives:

- Commissioners will need to structure contracts to achieve long-term outcomes that deliver value as described by Porter (2010). Criteria will include displacement, so that the downside impact of change will be considered – addressing the High Court's criticism of the Cumbria tendering process in which this criterion was excluded. Commissioning will therefore not be merely transactional, but instead strategic and transformational
- ACOs will need to deliver value, and this can only be achieved by presenting an integrated, upstream, long-term offering that reflects civic good rather than shareholder value. Healthcare in this era of civic good is not a money-making, transactional process, and ACOs will find that the bar has been raised as they tender for opportunities. Some will also find that shareholders are being asked to stay in for longer than they wish to receive a return on their investment. Therefore, ACOs from the charitable sector, in the NHS family and social enterprises will find the opportunities more suited to their ethos and structure.

Emerging themes

When reflecting on the discussion in this and the previous two articles, several themes emerged.

First, while the days of the internal market are coming to a close, this does not mean the end of competition. There will still be a need to allocate resources and ensure that results are achieved. This will be strategic commissioning at the level of an integrated care system, place-based commissioning at the locality level, and performance management for ACOs. Instead of win-lose competition, we will see more 'contestability' – the relational working between buyer and supplier, with competitive tendering used as a last resort. Commissioning has always been a Cinderella function, and it will need further strengthening to offset the weight of providers so that they do not recapture the market.

> "There will still be a need to allocate resources and ensure that results are achieved"

Second, contracting needs to get smart. It needs to become outcome-focused, value-adding and relational, rather than being a blunt instrument for transactional activity. Disruption from change of supplier needs to be factored into the criteria, not to protect incumbents but rather to reflect the impact of change on the ground. There is no sense in tendering for tendering sake; rather, the process should be carried out when there is a clear case for change. ACOs will not be excluded, and they will find rigour in the contracting process that reflects the expectations of transformational change.

Third, the emphasis needs to be on upstream activity. The aim of the internal market was to move away from provider capture of the market, and this needs to be accelerated by commissioning preventive health, drawing in non-health partners, and engaging citizens and communities in taking proactive, preventative action. Commissioning decisions in this context will be in the interests of the public and patients, not organisations, whose performance will be managed not just in relation to treatment of patients, but also in relation to their contribution to system value add.

Fourth, while the NHS needs to retain its clinically led focus when implementing integrated care this clinically led approach also needs to be balanced with the social model of care. If the NHS is to move away from being an illness service, the upstream work that should take precedence will not be led by clinicians. They will have a role to play, of course, but as partners in provision rather than the leaders.

Fifth, information needs to be freely available. One of the many reasons for the failure of the UnitedCare Partnership contract in Cambridgeshire and Peterborough (The National Audit Office, 2016) was the absence or withholding of information among partners and commissioners. Tendering is an inexact science, and the numbers can too easily be wrong, as shown both in rail franchising and Circle's experience at Hinchingbrooke, where optimism bias was displayed in financial projections. Open book accounting goes some way to addressing this, but there also needs to be more

effective use of NHS datasets to tell the system story and get behind the numbers – to join the dots. Citizens and communities also need to have full access to the facts so that they can be partners in the hard choices.

Sixth, the finite financial resources will need to shape behaviour, so it becomes 'our' money, not 'my' money. This is particularly the case for an ICS, but also for an ACO, which will hold a contract on merit and trust, offering public value rather than reaping rewards for shareholder value. Relational contracting will also reduce transaction costs, and integrated working will take away the need for costly mergers and acquisitions.

Finally, integrated care and ACOs need a new kind of leader. Business leadership does not need to be mercenary – just look at the legacy of Cadbury, Lever, Guinness and Peabody. They were disruptive, otherwise they would not have made their fortunes that enabled them to become public benefactors. The NHS post-internal market needs benevolent, disruptive leaders – ones who put the patient above their organisation, who eschew earning money and instead add value, and who work effectively with peers to ensure that the statues do not get in the way until they are changed.

Conclusion

Integrated care can indeed be the wonder drug that the NHS is in need of, but it is not a panacea. It will take time, perseverance, regulatory alignment and some measures of tough love to make it mean anything. As with any new drug, integrated care is still on trial, and let us hope that it is successful – there is no way back, and a future of competition that replicates the past quarter century is not something to look forward to. BJHCM

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