

## **Supplementary Evidence to the House of Commons Health and Social Care Committee on Integrated Care**

**26 March 2018**

I would like to respond to two related issues which the Committee raised and which I did not think were fully or fairly considered. Firstly, that it is unduly alarmist to describe ACOs and the changes that are taking place in the NHS as 'Americanisation'; and secondly that we are scaremongering.

There are many ways in which ACOs in England would resemble their equivalents in the US:

- they would not be statutory bodies and would be entitled to further their own interests
- the populations they would be funded to serve would comprise enrolees, not all the inhabitants of an area
- they would be allowed to compete for patients and practice lists
- they would be able to risk select patients and services
- they would operate via commercial contracts and sub-contracts, incurring the associated transactional costs including marketing, tendering, and bidding
- they would receive individual risk-adjusted whole population budgets
- they would be entitled to profit from and share gains made from not treating patients
- they would be entitled to charge for services, offer insurance policies and require top-ups
- their membership would be unrestricted; they could be investor-owned, including physician-investor owned
- they would not be able to measure area-based geographic inequalities
- they would not be designed to support social solidarity and universal risk pooling.

Most confusingly, NHSE has referred in its written evidence to the Canterbury ACO in New Zealand, as did Chris Ham in his oral evidence. This comparison is misleading and tendentious. New Zealand experimented with and then reversed its internal market with primary legislation in 2000, reintegrating its services under 22 district health boards (now 20).<sup>1</sup> The reinstatement of the Secretary of State's duty to provide and restoration of contiguous area based planning and services is exactly what I was urging the committee to call for for England.

Canterbury District Health Board is a statutory crown entity responsible for planning, providing, and funding primary, secondary, community, and hospital care serving residents in a geographic area. It owns and operates six major hospitals and almost 30 smaller hospitals and community bases. It also plans and provides some regional specialist services to other health board populations.

Canterbury District Health Board has been working hard to rebuild and restore functioning health services after the devastating earthquake - see its annual report<sup>2</sup>

In a personal email to me of 17 March 2018, which I have permission to share with the Committee, Ian Powell, the Executive Director of the Association of Salaried Medical Specialties in New Zealand, writes:

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<sup>1</sup> [http://www.euro.who.int/\\_data/assets/pdf\\_file/0007/98863/NEZsum112002.pdf](http://www.euro.who.int/_data/assets/pdf_file/0007/98863/NEZsum112002.pdf)

<sup>2</sup> <http://www.cdhb.health.nz/About-CDHB/corporate-publications/Documents/Canterbury%20Annual%20Plan%202016-2017.pdf>

*My first comment is that we **don't have an ACO** in Canterbury at least in the English NHS context and we don't use the term. Just because policy surfers might use the term that doesn't make it so,*

*What we have in the Canterbury District Health Board (a statutory entity responsible for primary and secondary, community and hospital care) is a low transaction cost relational rather than high transaction cost contractual approach in its relationship with NGO health providers and GPs. The main feature is several hundred clinically led and developed health pathways between community and hospital. It is not about shifting resources from hospital to community or public to private but more how the workforce is deployed (without changing employer) in the continuum of care. It is something we actually support because it is so much clinically led and rooted. It does not involve high transaction processes, contractualism, or privatisation of any form*

The Committee asked whether we were frightening patients in making them think they will have to pay for care. I strongly reject this suggestion.

There are several ways in which patients are now greatly at risk of either not receiving care or having to pay for it out of their own pocket, and ACOs, as currently proposed, are likely to make this worse, for example:

- 1 By reducing the range and volumes of activity funded and paid for by the NHS, and increasing waiting lists, as a result of the estimated £26bn+ savings that have to be made in services through budgetary cuts and service closures, as highlighted by STP plans. NHSE's announcement to stop a whole month of elective surgical care, and many CCG statements on curtailing or reducing some services attest to this.
- 2 By providers delisting NHS funded services and commissioners agreeing to non-commissioner requested services falling out of the NHS through changes to licences<sup>3</sup>
- 3 By providers reducing the availability of NHS capacity and beds, particularly as foundation trusts may now dedicate beds and services to generating up to half their income from private sources and their deficits may put them under pressure to do so.
- 4 By shifting the boundary between what is NHS-funded and what is non-NHS funded care - there is plenty of precedent for this with long term care and continuing care.
- 5 By providers introducing top-ups and user charges for services no longer funded by the NHS or by placing restrictions and time-limits on care e.g., physiotherapy and speech therapy.
- 6 By reducing access to care and introducing up front charges for some people, eg, migrants.

Finally, I would add that one of my main concerns with the Committee's line of questioning in our session was that it seemed to derive almost entirely from selected case studies of integration, and the Committee's experience from certain visits and brief encounters. Whilst these are important in themselves, they are not a substitute for systematic evidence gathering and sound evaluations of that evidence, and have to be seen in the light of the findings of the NAO's report in February 2017 which included the following statements in its summary.

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<sup>3</sup> <http://www.bmj.com/content/349/bmj.g5603>

*Integrating the health and social care sectors is a significant challenge in normal times, let alone times when both sectors are under such severe pressure. So far, benefits have fallen far short of plans, despite much effort. It will be important to learn from the over-optimism of such plans when implementing the much larger NHS sustainability and transformation plans. The Departments do not yet have the evidence to show that they can deliver their commitment to integrated services by 2020, at the same time as meeting existing pressures on the health and social care systems.*

*In addition, the NAO found no compelling evidence to show that integration in England leads to sustainable financial savings or reduced acute hospital activity. While there are some good examples of integration at a local level, evaluations have been inhibited by a lack of comparable cost data across different care settings, and difficulty tracking patients through different care settings*

Moreover, demonstration sites and pilot projects such as these distract from the big picture of the overall direction of travel, and the ways in which the NHS as a universal public health system is now being dismantled, privatised, and remodelled along US ACO lines. The loss of geographic area-based population responsibilities for resource allocation and planning services, commercial contracting, and competition between providers for patients on primary care lists such that CCG populations will no longer align with all the residents in their area are all a hallmark of these changes.

It is a pity that Simon Stevens in his oral evidence to your Committee on 16 March 2018 sets out to discredit my evidence while steadfastly ignoring the incremental changes to legislation that have taken place since 1990 to NHS structures, resource allocation, and governance of the health system. This has echoes of the shameful episode of 2002 when the advisers, witnesses, and Health Select Committee members deliberately sought to discredit my evidence on research into PFI - research which has long stood the test of time.<sup>4</sup> If the Committee is minded in its report to refer to his discrediting of my evidence, or to base any of its recommendations upon his assertions, then I request the Committee's assurance that I would be given the opportunity to respond in detail before publication of the report.

Finally, the enormous harm caused by Lansley's Health & Social Care Act 2012 can only be repaired by primary legislation. I hope that the Health and Social Care Committee will urge the Secretary of State and NHS England to halt its ACO, ACS, and STP plans, reinstate GP practice boundaries to align with their CCG or local authority area, and propose legislation to reinstate the NHS in England as a universal public health service.

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<sup>4</sup> <http://www.bmj.com/content/324/7350/1354.2>