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BRIEFING PAPER

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Accountable Care Organisations

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Contents:

Contents

Summary

An Accountable Care Organisations (ACO) is a model of healthcare organisation where a provider, or group of providers, takes responsibility for the healthcare provision of an entire population. There is no fixed definition of an ACO, but the organisation usually receives an annual, capitated budget to deliver contractually agreed health outcomes.

The NHS in England's *Five Year Forward View* (2014) agenda focuses largely on the greater integration of healthcare providers to offer a more joined-up service for patients. The current Government views ACOs as a way to help deliver this.

In July 2017, NHS England announced eight areas which would become Accountable Care Systems (precursors to ACOs). In August 2017, a draft ACO contract was also introduced, which will allow Clinical Commissioning Groups (CCGs) to choose to commission ACOs in their areas. The Government has argued that some regulatory changes will be required in order for the ACO contract to be used.

The two month consultation around the draft ACO contract has been controversial, and a judicial review has been launched against the legality of the process. Another judicial review has been launched against the contract by the campaign group *999 Call for the NHS*, arguing that the annual, capitated payment method is not permissible under the current regulatory framework.

The proposed introduction of ACOs in the NHS in England has generated some commentary as to a potential increase in private sector involvement, in part due to the model's origin in the American healthcare system.

This briefing paper explores the above, as well as the future roles of CCGs and GPs in an ACO system.

As health is a devolved area, this briefing looks at England only.

1. Accountable Care Organisations (ACOs)

1.1 What are ACOs?

The term Accountable Care Organisations (ACOs) refers to an area-based model of healthcare provision, where a single body takes responsibility for the health needs of its entire population.

The King's Fund's 2017 explainer of ACOs sets out three core elements present in such a system:

- They involve a provider or, more usually, an alliance of providers that collaborate to meet the needs of a defined population.
- These providers take responsibility for a budget allocated by a commissioner or alliance of commissioners to deliver a range of services to that population.
- ACOs work under a contract that specifies the outcomes and other objectives they are required to achieve within the given budget, often extending over a number of years.[1]

The intention of ACOs is to operate in a more integrated manner than healthcare models that pay per procedure carried out.

The ACO approach was developed primarily in the American healthcare system, and following the passing of the Affordable Care Act in 2010, the number of ACOs has increased significantly. There is no defined model of how an ACO should be organised, with significant variation in the extent to which individual organisations are contractually integrated.

One of the more fully integrated models, Kaiser Permanente, with a single system and payment mechanism across all types of care, has been cited by the Health and Social Care Secretary, Jeremy Hunt, as an example of best practice in integrated care, alongside the Ribera Salud Grupo in Spain.[2]

According to 2014 analysis of American ACOs by the King's Fund, outcomes are mixed, particularly with regards to overall cost savings. However, the overall picture showed "some modest cost savings, mostly due to reduced A&E visits and lower hospital readmissions."[3]

Dr Ashish Jha, Director of the Harvard Global Health Institute, has argued that in order to import the ACO model to the UK successfully, there will need to be a changes in IT delivery and in working culture:

> While this (ACO) model is extremely promising, there are important issues that will likely need to be addressed:
>
> The first is having a health IT system that can facilitate true population health management. This means that all parts of the healthcare delivery system (and potentially other sectors, such as

1 The King's Fund, *Accountable care organisations (ACOs) explained*, June 2017
2 HC Deb 9 June 2014, c293
3 The King's Fund, *Accountable care organisations in the United States and England: Testing, evaluating and learning what works*, March 2014, p6

> social services) must be on an electronic platform and be able to communicate seamlessly with each other. Even though a majority of physicians and hospitals now have robust electronic health records in the U.S., critical patient data does not easily flow across these providers, making population health management extremely difficult.
>
> The second big challenge is in shifting the culture and mindset of providers. In the U.S. ACOs identified that getting physicians to change their practice style from a fee-for-service approach to an integrated, population-health approach is very challenging. Surely, this kind of change will be a challenge in the UK as well, and all the evidence suggests that it takes time and persistent effort.[4]

1.2 ACOs in the NHS

NHS England's 2014 *Five Year Forward View* (5YFV) publication introduced ACOs as a way to integrate primary and acute medical care in the NHS. They were cited as a similar model to the Primary and Acute Care Systems (PACS) new care model (see Box 2 below for more information on PACS):

> At their most radical, PACS would take accountability for the whole health needs of a registered list of patients, under a delegated capitated budget - similar to the Accountable Care Organisations that are emerging in Spain, the United States, Singapore, and a number of other countries.[5]

5YFV looked at Clinical Commissioning Groups (CCGs) as the appropriate local delivery level for ACOs. However, by the time that *Next Steps on the NHS Five Year Forward View* ('*Next steps*') was published in 2017, this had been changed to the 44 larger Sustainability and Transformation Partnership (STP) areas.[6]

Next steps introduced Accountable Care Systems (ACSs), which would see CCGs and providers (such as NHS trusts, GPs and community healthcare providers) within an STP area working together to manage funding for their defined population. Where areas agreed an accountable performance contract and jointly managed funding for their population, *Next steps* stated that ACS areas would be offered:

- Delegated local commissioning powers over primary care and specialised services (currently commissioned by NHS England);
- A devolved transformation funding package; and
- Streamlined oversight arrangements with NHS England and NHS Improvement, as well as staffing and funding support.[7]

In June 2017, the Chief Executive of NHS England, Simon Stevens, announced the first eight areas that would take on ACS status. Between them, these areas serve a population of close to seven million people and could potentially have control of transformation programme

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4 A Jha, 'US healthcare reform: Lessons for the UK', *Nuffield Trust comment*, 16 March 2015
5 NHS England, *Five Year Forward View*, October 2014, p21
6 More information on STPs can be found in the Commons Library briefing paper, *Sustainability and transformation plans and partnerships* (CBP 8093)
7 NHS England, *Next Steps on the NHS Five Year Forward View*, March 2017, pp35-7

funding worth £450 million over the next four years.[8] The eight areas announced, covering either full STP or partial STP areas, were:

- Frimley Health including Slough, Surrey Heath and Aldershot
- South Yorkshire & Bassetlaw, covering Barnsley, Bassetlew, 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
- Buckinghamshire.

It was also announced that West, North and East Cumbria, and Northumberland could join the group of ACSs later in the year, and that devolution deals in Greater Manchester and Surrey Heartlands would also give more financial autonomy in return for greater integration.[9]

Next steps also defined ACOs as more advanced, more integrated forms of ACSs, and set a general target to move towards these at some point in the future:

> In time some ACSs may lead to the establishment of an accountable care organisation. This is where the commissioners in that area have a contract with a single organisation for the great majority of health and care services and for population health in the area. A few areas… in England are on the road to establishing an ACO, but this takes several years. The complexity of the procurement process needed, and the requirements for systematic evaluation and management of risk, means they will not be the focus of activity in most areas over the next few years.[10]

Box 1: ACOs and ACSs

As set out above, *Next steps on the Five Year Forward View* defines ACOs as a more advanced ACS, but this is not always how the terminology is used. Often the two terms are used interchangeably.

The British Medical Association (BMA) briefing on ACSs states that the major difference between these and ACOs is that ACOs "there will be a **single contract with a single organisation** for the majority of health and care services and for population health in the area." This appears consistent with the distinction set out in *Next steps*.

There has been some debate as to whether the creation of an ACO, with an annual capitated budget would be legally possible under current healthcare legislation (see section 3.1 for more information).

The recent Government consultation on a model ACO contract made no mention of ACS. Recent Government statements have also confirmed that it will be up to CCGs to decide whether or not to commission an ACO contract for their area, in a seemingly different process to the ACS to ACO transition set out in *Next steps*.

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8 'Simon Stevens names the first accountable care systems', *Health Service Journal*, 15 June 2017

9 NHS England, *NHS moves to end "fractured" care system*, 15 June 2017

10 NHS England, *Next Steps on the NHS Five Year Forward View*, March 2017, p37

Between 11 September and 3 November 2017, the Department of Health carried out a consultation on proposed changes to regulations which would allow for the introduction of a model ACO contract (see section 1.3). The Government has not yet published a response to the consultation, but it has stated that it would like to implement the regulatory changes by February 2018.

Box 2: New Care Models – MCPs and PACS

The 5YFV introduced seven 'New Care Models' to support better working between traditional healthcare divides (such as primary care, community care and hospital care). Two of these models, Multispecialty Community Providers (MCPs) and Primary and Acute Care Systems (PACS) are precursors to the development of ACOs in the NHS.

Both are population-based care models based on the GP registered list, but vary in scope and scale. Both include primary, community, mental health and social care, but a PACS also includes most hospital services.

According to the MCP framework, an MCP will need a population of 100,000 at a minimum, but could be much larger, whereas a PACS will provide care for all the population served by its acute hospital trust, generally at least 250,000.

Following the publication of 5YFV, NHS England established nine PACS and 14 MCP 'vanguards' to trial the models, covering around eight per cent of the population of England.

The consultation also sought to clarify some of the terminology around ACOs:

> As the policy has developed, the terminology used to describe these new ways of providing and commissioning services has evolved. MCPs and PACS are two of the new models of care described in the Five Year Forward View. MCPs and PACS are both types of whole population provider. Where these models are formalised through the use of a contract, organisations delivering both the MCP and PACS care models are forms of ACO. For the purposes of some of the regulations, they are defined as an 'integrated services provider', to make it clear that this includes the type of ACOs in which primary medical services are commissioned through a single contract in an integrated way with other services.[11]

The Department of Health's *Mandate to NHS England for 2017-18* called for 20% of the population to be covered by new care models (including MCPs and PACS) by the end of the year and 50% by 2020.[12]

1.3 Draft ACO contract

In August 2017, NHS England published a draft ACO contract.

Three levels of GP participation were envisaged as part of these new contractual arrangements, which vary in the extent to which GPs are contractually bound into the new organisation. The three levels are:

- Full integration – The ACO brings together all primary care services operating under a single, integrated budget.

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11 Department of Health, *Accountable Care Organisations: Consultation on changes to regulations required to facilitate the operation of an NHS Standard Contract (Accountable Care Models)*, September 2017, p5

12 Department of Health, *The Government's mandate to NHS England for 2017-18*, March 2017, p21

- Partial integration – The ACO excludes primary services covered by the General Medical Services (GMS) and Personal Medical Services (PMS) contracts held by most GPs. Additional contractual arrangements are made between the ACO and GPs to achieve operational integration.
- Virtual integration – where separate commissioning contracts are bound together.

  In this model, providers would enter 'alliance agreements' with the commissioning bodies, which would overlay regular commissioning processes. Providers would likely agree to work towards greater integration. The BMA has argued that this model is "effectively an ACS rather than an ACO."[13]

A *Health Service Journal* report on the model contract highlighted various organisational forms the ACO could take:

> The documents identify a number of "organisational forms" which could hold the ACO contract. These include:
>
> 1. A GP owned organisation, which could take the form of a limited company by shares or limited liability partnership;
> 2. Corporate joint venture in which GPs and another organisation come together to form a new legal entity;
> 3. An existing NHS body, for example a foundation trust or NHS trust;
> 4. A "host arrangement", in which an organisation hosts the ACO contract but decisions are made through a "forum" of partners from other providers.[14]

The Government has argued that some regulatory changes are necessary to enact the draft ACO contract. These were consulted on between 11 September and 3 November 2017, and included proposed changes such as allowing GPs to suspend, rather than cancel, their contracts with NHS England in order to join an ACO. The consultation document stated that the Government hoped to have any regulatory changes in force by February 2018, and that a consultation on a final contract would take place later in 2018.[15]

When asked in a Parliamentary Question why the new regulations were intended to be introduced prior to a full consultation, Health Minister Steve Brine responded that changes were required to allow certain selected CCGs to test out the draft contract before it was finalised:

> NHS England intends to permit a small number of clinical commissioning groups, under its oversight, to use locally developed versions of its draft ACO contract to commission ACOs for their populations. The learning from this will inform any future development of the draft ACO contract. NHS England has committed to consulting on the draft ACO contract before any

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13 NHS England, *Whole population models of provision: Establishing integrated budgets*, August 2017, p10; More information on the models can be found on the BMA page, *ACO and ACS* (November 2017)

14 'NHS England reveals first national contract for ACOs', *Health Service Journal*, 7 August 2017

15 Department of Health, *Accountable Care Organisations: Consultation on changes to regulations required to facilitate the operation of an NHS Standard Contract (Accountable Care Models)*, September 2017

> decision is made to issue it as a contract for wider use in the National Health Service, in accordance with its duties under regulation 18 of its Standing Rules (SI 2012/2996). The consultation conducted by NHS England under regulation 18 will offer an opportunity for scrutiny of the proposed ACO contract before it is published for general use.
>
> To enable the draft contract to be tested NHS England has requested the Secretary of State to make amendments to a number of regulations. The Department has consulted publicly on those changes to regulations. This consultation closed on 3 November. We are currently considering the responses and whether any further regulatory changes may be needed. The Government will formally respond in due course.[16]

A January 2018 article in the *Health Service Journal* reported that Dudley CCG is looking to introduce an advanced ACO contract, which would integrate GP services with other providers, but that this may not be in place until April 2019.[17]

On 6 December 2017, an Early Day Motion was introduced, sponsored by MPs including Leader of the Opposition, Jeremy Corbyn, and Shadow Health Secretary, Jonathan Ashworth, calling for sufficient debate on ACOs prior to any regulatory changes.[18]

The BMA has also raised concerns about the extent of consultation on the proposed changes:

> NHS England and the Department of Health must invite full and proper scrutiny of the current proposals, with maximum transparency. We do not believe that the current consultation process, based on the narrow technical legal aspects of required regulatory changes, properly allows this.[19]

In addition, one of the legal challenges against the introduction of the ACO contract also focuses on the adequacy of the Government's consultation process (see section 3.2).

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16 PQ 115613 [Health Services], 4 December 2017
17 'Exclusive: Pioneering NHS ACO contract set back', *Health Service Journal*, 5 January 2018
18 EDM 660, 6 December 2017
19 BMA, *Accountable care models contract: proposed changes to regulation*, November 2017

2. Role of CCGs

An ACO refers to the integration of healthcare providers (hospital trusts, GPs, community services etc.) into a single organisation. Its creation, however, also has an impact on the commissioners of healthcare services, particularly local Clinical Commissioning Groups (CCGs).

Under the *Health and Social Care Act 2012*, CCGs have statutory duties around the commissioning of healthcare for their populations. These will not be altered by the establishment of an ACO for an area. Although ACOs will be accountable through quality and outcomes measures in their contracts, they do not yet have a legislative basis and therefore statutory accountability will remain with CCGs and other NHS bodies.

The NHS England guide, *ACOs and the NHS commissioning system*, states that CCGs will not be able to delegate responsibility for their statutory roles, but should work closely with ACOs in the delivery of healthcare services:

> CCGs will continue to be responsible and accountable for the delivery of their functions. They have the flexibility to decide how far to carry out activities related to these functions themselves; including in groups (e.g. through lead CCG arrangements); or through external commissioning support. They may also require, through contract provisions, an ACO provider to take action to support the discharge of certain CCG duties (e.g. to reduce inequalities or ensure patient choice). However, in all these instances the CCG will retain responsibility for its functions. These cannot be delegated. As part of the process of establishing an ACO, CCGs will need to assure themselves and NHS England of their ability to discharge their statutory functions.[20]

The guidance states that a shift in activities from a CCG to an ACO may entail changes to CCG governance structures, and may also require the creation of a pooled budget.

CCGs are also responsible for determining whether to commission an ACO for their area, and whether such a contractual arrangement is appropriate, as stated by Health Minister Steve Brine in an October 2017 Parliamentary Question response:

> It is for local commissioners to commission services according to the needs of their local population. The Commissioner must run a procurement process that is compliant with the principles of transparency and equal treatment.
>
> The CCG would need to be satisfied that the bidder can effectively provide the services in the required locality as specified within the tender, and the commissioner can design the award criteria to reflect the service being contracted, so could include, for example: ensuring quality, continuity of service, accessibility, affordability, availability, Care Quality Commission assessment, needs of vulnerable patients, teaching accreditation, continuity, and comprehensiveness of the services etc. Neither the advert nor the criteria should specify the organisational form of the body that

[20] NHS England, *ACOs and the NHS commissioning system*, August 2017, para 7

> will be awarded the contract. It will be for bidding providers to determine the ownership model of that provider.[21]

The Government has stated that CCGs are responsible for determining whether or not to commission an ACO,[22] based on its appropriateness for their area. This appears to be a separate process for establishing an ACO to the one set out in section 1.2, where NHS England determines which advanced STP areas are to become ACS areas (which can then become ACO areas at a later date).

In the debate on the 2014 Queen's Speech, the Health Secretary Jeremy Hunt stated that:

> We are doing one more important reform: we are taking the first steps to turn the 211 clinical commissioning groups into accountable care organisations with responsibility for building care around individual patients and not just buying care by volume.[23]

This statement related to allowing CCGs to co-commission primary care alongside NHS England, rather than any changes to their statutory roles, but it was not stated whether any other changes were envisaged to 'turn CCGs into ACOs'.

In June 2017, the then Chief Executive of NHS Improvement, Jim Mackey, stated that "90%" of progress on the creation of ACOs could be made within the current legal framework, indicating that major changes to the statutory duties of CCGs were not forthcoming.[24]

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21 PQ 105251 [Health Services: Contracts], 11 October 2017
22 Also see PQ 9710 [Health Services], 18 September 2017
23 HC Deb 9 June 2014, c293
24 'Mackey denies legal constraints as accountable care systems confirmed', *National Health Executive*, 19 June 2017

3. Legal challenges

The introduction of the draft ACO contract (see section 1.3) is currently facing two legal challenges, one from the campaign group *999 Call for the NHS*, and another from a group of five campaigners including Professor Stephen Hawking, known as *JR4NHS*.

3.1 999 Call for the NHS

The campaign group *999 Call for the NHS* have argued that the ACO contract's shift to a single, annual budget for a population, rather than a payment by services used model, breaches current legislation. An October 2017 *Health Service Journal* report on the case summarised the issues as follows:

> A campaign group, backed by law firm Leigh Day, has lodged a judicial review claiming the contract for accountable care organisations breaches the Health and Social Care Act 2012.
>
> NHS England said it would "strongly resist" the claim and the "mistaken campaign" was an attempt to "frustrate the move to more integrated care".
>
> The law firm submitted review papers on Monday on behalf of the "999 Call for the NHS" campaign group, arguing the contract breaches sections 115 and 116 of the act.
>
> These sections relate to the price a commissioner pays for NHS services and regulations around the national tariff.
>
> The judicial review argues that under current legislation, prices paid for NHS services must reflect how many patients receive the care under that specific service, whereas the ACO contract allows commissioners to give providers a fixed budget for an area's population.[25]

Rowan Smith, the solicitor leading on the case, argued that the Government was attempting to circumvent current protections for patients "through the back door and outside of the existing statutory framework.[26]

According to the campaign group, the application for judicial review has been accepted, and will be heard on a date after 16 February 2018.[27]

3.2 JR4NHS

In November 2017, a group of four campaigners, Professor Allyson Pollock, Dr Colin Hutchinson, Professor Sue Richards and Dr Graham Winyard, launched their campaign against the ACO contract under the campaign name *JR4NHS*.

The group's case appears to contest the legality of the consultation process around the draft ACO contract. As set out in section 1.3, a consultation was held between September and November 2017 on

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25 'NHS England to 'strongly resist' legal case against accountable care contract', *Health Service Journal*, 27 October 2017

26 Leigh Day, *Campaigners launch judicial review against NHS England*, 9 November 2017

27 999 Call for the NHS, *Our Judicial Review*, last accessed 8 January 2018

technical changes to regulations; for example allowing GP contracts to be dissolved so they can join ACOs (see section 1.3). However, JR4NHS argues that this was insufficient, and that as these regulatory changes will come into force in February 2018 before a full consultation on ACOs, which has been planned for later in 2018, stating that:

> The Secretary of State is therefore pre-empting the lawfulness of that future consultation because it must be carried out when any NHS England proposals are at a formative stage.[28]

According to the group's second stage Crowd Justice page, Professor Stephen Hawking joined as a signatory to the case on 8 December 2017, and the case was filed in court on 12 December.[29]

28 JR4NHS, 'Urgent Legal Action for our NHS #JR4NHS', *Crowd Justice*, (last accessed 4 January 2018)

29 #JR4NHS, 'Urgent Legal Action for Our NHS – Round 2', *Crowd Justice*, (last accessed 4 January 2018)

4. Comment

4.1 Private sector involvement

Much of the debate surrounding the introduction of ACOs to the NHS has focused on the potential for greater private sector involvement.

In its response to the Government's consultation on the draft ACO contract, the BMA raised concerns on this issue:

> Combining multiple services into one contract risks the potential for non-NHS providers taking over the provision of care for entire health economies, as the contract would be subject to open competition rules. Moreover, a single ten-year contract would force re-procurement each time and create significant uncertainty. The BMA strongly supports the ongoing provision of a publicly funded and publicly provided NHS, and calls for the government to clarify what safeguards will be in place to ensure that ACOs do not enable an increase in the role of independent sector providers in the NHS.[30]

Some concerns regarding potential privatisation stem from ACOs' emergence out of the US healthcare system, which is based to a much greater degree on private health insurance. In a 2016 article for the Huffington Post, Shadow Health Minister Justin Madders argued that:

> ACOs are commonplace in the USA and whilst the official language over here is about them looking at "place based" working, the fact that on the other side of the Atlantic they are intimately connected to the private insurance system is bound to raise questions about where this is heading.[31]

As a result of concern from some commentators about the 'Americanisation' of the NHS through ACOs, the *Health Service Journal*, in a January 2018 article on predictions for the coming year, predicted that:

> "Accountable care" as a label within the NHS will die before the first new organisation gets going. The American source of the name and the connotations of "privatisation" it brings is an irritation NHS England could do without. This is likely to be the most notable victory for the anti-ACO campaigners, though the lack of statutory footing for new systems will continue to plague their development, especially when it comes to how the quality of the care they oversee should be monitored.[32]

In an article for the *Guardian* in January 2018, the outgoing National Medical Director of NHS England, Professor Sir Bruce Keogh, argued that the eight announced ACSs were attempts to "unite a fractured system" and were not the "Trojan horse for privatisation that some critics may fear."[33]

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30 BMA, *Accountable care models contract: proposed changes to regulation*, November 2017

31 Justin Madders, 'Revealed: Tory Plans for Hospital Closures and Further NHS Privatisation', *Huffington Post*, 8 August 2016

32 'What 2018 will bring for NHS patients, staff and leaders', *Health Service Journal*, 1 January 2018

33 Professor Sir Bruce Keogh, 'The NHS turns 70 this year, and it's Britain's greatest medical innovation', *The Guardian*, 1 January 2018

4.2 Role of GPs

Concerns have also been raised about the role of GPs in an ACO, with critics citing the model as a threat to GP independence. An article by Dr David Wrigley, published in December 2017 in *GP Online*, argued that:

> ACOs have the potential to remove the list-based general practice that has served our patients well since 1948 and consume all patients into the ACO with the role of the GP as yet being unclear. It may be that the GPs become salaried in their 'ACO practice' or salaried to the local hospital trust. It is hard to see the independent contractor model surviving such a shift in ethos of how the NHS is configured.[34]

Similar concerns have been raised by the BMA:

> Moving to a fully integrated ACO would also entail radically altering the current model of general practice and would be incompatible with GP independent contractor status. The national GMS contract underpins fair and consistent health service delivery in England, enabling GPs to act as independent advocates for their patients and local communities. The deterioration of the independent contractor status risks losing this, and breaking the personal relationship between local communities and GPs.[35]

As set out in section 1.3, NHS England guidance on the draft ACO contract envisages multiple models of GP participation, including a 'partial integration' model, where services covered by GMS and PMS contracts are excluded, and a 'virtual integration' model, where existing commissioning contracts are kept, but bound together.

4.3 Rationing of services

One of the purported benefits of ACOs is a capitated annual budget that allows providers to retain and share any savings made.[36] However, the potential for this has led to concerns from some commentators that ACOs could lead to rationing of services to deliver savings.

The JR4NHS campaign group (see section 3.2) has made this argument, as has the Shadow Health Secretary Jonathan Ashworth in a December 2017 article for the *New Statesman*:

> The government has given us no assurances that this process won't end up being just another cost-cutting exercise, leading to greater rationing of treatments locally. The NHS is already undergoing the greatest funding squeeze in its history, and with services at risk across the country, Accountable Care Organisations must not be used as a vehicle for yet more restrictions.[37]

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34 Dr David Wrigley, 'General Practice is on a cliff edge – and ACOs could tip it over', *GP Online*, 8 December 2017

35 BMA, *Accountable care models contract: proposed changes to regulation*, November 2017

36 'Accountable care organisations: the future of the NHS?', *National Health Executive*, Mar/Apr 2016

37 Jonathan Ashworth, 'It's time for NHS transparency – starting with the government's secretive Accountable Care plans', *New Statesman*, 8 December 2017

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