

The Health and Social Care Act for England 2012: The extension of 'new professionalism'

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Abstract

The 2012 Health and Social Care Act, introduced by the coalition government, has been seen as fundamentally changing the form and content of publicly funded health care provision in England. The legislation was hugely controversial and widely criticized. Much of this criticism pointed to the ways in which the reforms undermined the funding of the National Health Service, and challenged the founding principle of free universal provision. In this commentary we take issue with the argument that the Act represented a radical break with the past and instead suggest that it was an extension of the previous Labour government's neo-liberal reforms of the public sector. In particular, the Act invoked the principles of 'new professionalism' to undermine professional dominance, and attract private providers into statutory health care at the expense of public providers. In turn, this extension of new professionalism may encourage public distrust in the medical profession and absolve the state of much of its statutory health care obligation.

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Introduction

The enactment of the Health and Social Care Act in England in March 2012 marked the end of one of the most controversial periods of reform in the history of the National Health Service (NHS). As such, it marks a fundamental transformation of the founding principles of the NHS (Pollock et al., 2012) or even the end of the NHS itself (Pollock and Price, 2011; Bailey, 2012). Since its inception (in 1948) the NHS has provided statutory universal health care (free at the point of need) for every citizen. It has been universally accessible, based on need not ability to pay. Critics, such as Pollock et al. (2012) have argued that the reforms, through the introduction of competitive markets, mixed funding models and widespread private provision will erode ‘entitlement to equality of provision’, thus revoking a founding NHS principle of universal equity of access and ultimately leading to the end of statutory free and universal public health care. Conversely, there is an assertion, from government, that these reforms will improve levels of efficiency and effectiveness, thus improving the patient experience of care in the NHS, although the evidence for this is ambiguous at best.

The Act also raises a central question about statutory obligations. For example, the initial iteration of the Bill attempted to replace the statutory ‘duty to provide’ free universal health care with a statutory ‘duty to promote’ such health care. So great was the controversy around the programme of reform that the Bill was subjected to an almost unprecedented three month ‘halt’ in the legislative process, to enable the coalition government (in their words) to ‘pause, listen [to] and reflect’ opinions towards the planned legislation from assorted medical stakeholders and the general public (Hawkes, 2011). The reforms proposed a number of significant changes to *two key areas*, firstly, to the structure of the National Health Service (NHS), and secondly to the delivery of NHS care.

The 2010 White Paper (which effectively set the reform agenda) asserted that the NHS had poor comparative outcomes in relation to mortality rates for ‘some respiratory diseases and some cancers’, for ‘acute complications of diabetes and avoidable asthma admissions’, and for infection rates of methicillin-resistant *Staphylococcus aureus* (MRSA) (DoH, 2010: 8). The NHS was also identified as scoring ‘relatively poorly’ on patient responsiveness measures, and was generally criticized for a lack of ‘consistency of excellence’ (DoH, 2010: 8). Framed in these terms, there was a clear crisis in the NHS. By presenting the problem as one of purportedly poor comparative outcome

measures the government also determined the shape and tenor of possible solutions. The accompanying rhetoric was concerned with a need for better regulation and more measurement to improve outcomes and to ensure that the NHS could enhance its performance on key indicators. However, just one month prior to the publication of the 2010 White Paper, the Commonwealth Fund published a comparative review of international health care systems (across Australia, Canada, Germany, the Netherlands, New Zealand and the United States), which demonstrated that the NHS was the top rated country in terms of levels of efficiency and effectiveness of care (see Davis et al., 2010). Similarly, Pritchard and Hickish (2011) found that England and Wales showed a higher reduction in cancer mortality rates when compared to a range of seven other major developed countries, between 1979 and 2006 (across Australia, Canada, France, Germany, Italy, Japan, the Netherlands, Spain and the United States). There is thus a clear disparity between the White Paper and the research evidence. Ironically given the evidence based outcomes focus of the reformed NHS, it would appear the government are putting their desired outcomes ahead of the evidence.

In this context the coupling of inefficiency/ineffectiveness to the need for efficiency savings creates a 'perfect storm' for which competition between providers across a range of new outcome measures presents the best 'apparent' solution. In this commentary we outline how these reforms, couched as they are in terms of a prevailing neo-liberal orthodoxy, are best regarded as an extension of principles of accountability based 'new professionalism' (Light, 2010). These principles bolster a shift in public sector provision towards 'buyer-dominance', with the state positioned as the most powerful actor in the field of provision. Crucially this does not mean that the state is the dominant or monopoly provider, indeed far from it. Rather it means that the state, rather than the professions, the patients, the providers (non-statutory and statutory), or the medico-industrial complex, is the dominant figure in determining the form and function of health care provision. Below we demonstrate the ways in which the Health and Social Care Act (2012) facilitates this dominance. We commence by considering changes to the overall structure of the NHS in terms of Clinical Commissioning Groups (CCGs), before turning to the changes in the delivery of care through the creation of Any Qualified Provider (AQP) roles (NB: the original White Paper and the initial Bill referred to 'Any Willing Provider' but this was amended following the report of the NHS Future Forum).

'Clinical Commissioning Groups' and 'any qualified provider'

In terms of the first key area, the 'headline' alteration to the structure of the NHS involved a change in the role of General Practitioners (GPs), particularly

in relation to primary care provision. The initial White Paper and the first iteration of the Bill proposed creating 'local' GP Commissioning Consortia (GCCs), which would have statutory responsibility for spending the majority of the national NHS commissioning budget (Powell, 2011). After the initial report from the NHS Future Forum the name of GP Commissioning Consortia was amended to Clinical Commissioning Groups, in a move to appease other professional bodies unhappy at the apparent GP dominance in the commissioning process (Powell, 2011). Previously health care commissioning had been the responsibility of Primary Care Trusts (PCTs) involving GPs, practice nurses, community pharmacists and optometrists. It was now to be devolved solely to groups or consortia of GPs in what was a much narrower concentration of power. This is not to say that PCTs were exemplars of participatory democracy across professional groupings. Rather, as Smith and Goodwin (2006) note, GPs in the old PCTs did not hold a monopoly on representation to the extent that was proposed within GCCs in the initial Health and Social Care Bill (2011).

In the original Bill GCCs had no obligation whatsoever to look beyond GPs for membership or governance. Unsurprisingly other professions and lay organizations objected. In part this explained the aforementioned pause in the legislative process and consequent formation of the NHS Future Forum. The Future Forum was set up with the explicit purpose of providing platforms for staff and patients to feedback to government on the proposed reforms. Its members were drawn from non-statutory charitable organizations, local authorities, primary and secondary care and universities, and it was chaired by a GP, Professor Steve Fields. Following the consultation, the NHS Future Forum reported that there was a need for secondary care professionals, nurses and non-professional people to be involved with GCCs. An amendment was added to the Bill, requiring that the governance or management boards of GCCs had to contain at least one secondary care professional and a lay member. Just to be clear, this related only to the governance board of the GCC; the GCC itself was still a GP-only organization. It was at this point that the name of GP Commissioning Consortia was amended to Clinical Commissioning Groups (CCGs). The creation of CCGs has implications for issues of governance, regulation and modes of professional working that we explore below.

In terms of the second key area, care delivery, the Act moved to deregulate care provision through the introduction of mechanisms that enabled 'any qualified provider' (AQP) to tender for contracts from the CCGs. These AQPs can be private, public or third sector organizations. The introduction of AQPs shifts NHS professionals into an explicit market context where they compete for contracts against any number of statutory and non-statutory providers as part of wider moves intended to inculcate market competition in public sector provision (see Black, 2010). At the time of

writing this has resulted in private sector companies such as Serco and Virgin Care successfully tendering to provide statutory community services, sexual health services and prison health care services across a number of English NHS Trusts. Of course these companies were involved in NHS provision before the Bill. What is new, post legislation, is that the changes have resulted in private companies becoming the principal providers of those services such that NHS employees are required to move from NHS contracts on to private sector company contracts (in a process known as the Transfer of Undertakings (Protection of Employment) or TUPE). This process functions to move staff out of the public sector and out of the direct purview of the Secretary of State for Health. Whilst TUPE-ing also happened under the previous government, the Bill enables an unprecedented extension of this process across much larger numbers of staff (including practitioners and support staff).

The context of ‘new professionalism’

In seeking to understand these reforms, as noted earlier, we draw from Light’s (2010) work on ‘new professionalism’ in health care. This notion is characterized by three key and novel practices of governance and accountability. Firstly, there is a shift from a training-and-licence based model of accountability to a competency/performance based model. Secondly, there is a shift from embodied trust based on reputation, competence and empathy (see Calnan and Rowe, 2008) towards a new form of ‘enforceable’ or informed trust. Such trust moves away from principles of self-regulation, and is based instead on externally generated standards of competency and performance (external in the sense that it is outside the direct influence of the professions). Thirdly, this competency/performance model facilitates the development of a new team model of care, such that ‘non-physician clinicians’ (or by extension ‘AQP’) can undertake professional work.

Below we show how the Health and Social Care Act invokes these new forms of accountability as part of a process of professional governance. However, these novel forms of accountability do not mark a fundamental departure from previous forms. Rather they rearticulate existing regulatory frameworks introduced under the previous Labour government that appealed to established external standards, such as Evidence Based Medicine (EBM) and clinical and patient outcome measures. Coupled with a concomitant shift away from professional autonomy, these processes of new professionalism mark a continued and systematic attempt to further embed principles of buyer-dominance into the field of statutory health care in England. We first consider new models of competency and performance.

New competency and performance models

The first of Light's (2010) new-accountability criteria is evidenced in the legislation through a restated focus on outcome measures (in terms of both clinical and patient outcomes) and through the creation of a number of regulatory roles to assess professional performance against these new measures. The Act positions clinical outcome data and international best clinical practice as key determinants of clinical performance, and thus gives primacy to a model of evidence based medicine (EBM). Furthermore, these standards of clinical evidence are combined with routinely collected patient outcome and patient experience data to ensure the 'highest quality of care' (Health and Social Care Act, 2012) is delivered to patients. All of these indicators have been crafted in such a way as to deflect any claims of political interference. They all purport to draw from an evidence base beyond the realm of political influence. There is a strong appeal to scientificity, such that any difficult or awkward decisions might now be justified on the basis of scientific 'evidence'. These decisions come to be seen as matters of best practice rather than economics or ideology. However, as DeVries et al. (2008) point out, appeals to such standards of 'objectivity' are often highly politically motivated. In terms of treatment decisions, responsibility over who does, and more importantly who does not, get treatment is now legitimized through an apparently objective evidence base.

In terms of professional regulation, this will be measured by three newly tasked bodies; the Care Quality Commission (CQC) will regulate the 'quality' of provision, Monitor will regulate the 'cost' of provision and the NHS Commissioning Board will monitor the 'efficacy' of provision. In addition, Clinical Commissioning Groups (CCGs) will hold *all* health care providers to account in terms of commissioned health care outcomes at a local level. All of these new regulatory measures have a clear remit in terms of issues of governance and performance and move the reformed NHS much more explicitly towards an outcome focused approach. For example, the Commissioning Outcomes Framework (COF) will hold CCGs to account in terms of measurement of clinical effectiveness, patient experience and patient safety data; these data will be routinely collated from other sources, such as the existing Quality and Outcomes Framework (QOF) utilized by GPs. In turn, the NHS Commissioning Board will be managed through the NHS Outcomes Framework, which will have three key functions; firstly, to provide a national overview of NHS performance (with reference to international benchmarks), secondly, to make the NHS Commissioning Board accountable to the Secretary of State for Health, and thirdly, to manage performance and improve outcomes across the NHS. Importantly, the National Institute for Health and Clinical Excellence (NICE) is developing both of these frameworks, based on current best national and international evidence. Again, the

locus for evidence is external, purportedly beyond the sphere of political influence (from either government or the professions). Salter (2004) argued that much of the professional regulation undertaken in the NHS under New Labour was unsuccessful because health professionals staffed the regulatory organizations, such as NICE. The new Act combines international EBM, and patient experience and patient outcome data, as a means of introducing external loci of 'evidence' into the governance frame, such that the potential for professional dominance of the regulatory regime is lessened. Couple these new loci with the prevailing economic imperatives and the implications of these reforms in terms of clinical practice and professional regulation become a little clearer. This brings us to the second of Light's (2010) criteria – what he describes as a new form of trust to underpin professional practice.

Enforceable trust

The reforms embed new modes of governance and regulation that move further and further away from professional self-regulation and embodied trust in professionals (Calnan and Rowe, 2008) towards informed or enforced trust (Light, 2010). We draw attention here to the role of the state in the apparent demise of professional trustworthiness. Ham and Alberti (2002) state that a number of UK health care scandals (such as Alder Hey and Bristol) 'hasten[ed] the demise of the implicit compact between the state, the medical profession and the public' (cited in Elston, 2009: 25). Certainly with the advent of New Public Management (NPM), trust between newly regulated medical practitioners and reforming governments became strained. The rise, under New Labour, of processes of network governance founded on new modes of clinical governance and performance management did little to improve these strained relations (Speed, 2011).

In terms of the reformed NHS, Ferlie (2010) asserts that given the prevailing austerity culture, the most likely outcome is a resurgence of NPM principles, and these principles are central to notions of enforceable trust. The associated rhetoric of government distrust in professionals, and consequent changes to the extent and degree of professional self-regulation are again of a piece with the inculcation of buyer-dominance in the public sector. In detailing these shifts from provider driven to buyer driven public services Light characterizes 'trust' in ideological terms. He portrays the provider driven context as one dominated by 'sacred trust in doctors' whereas the buyer driven context is dominated by 'distrust of doctors' values' (2010: 278). This distrust, for Light, is attributable to four distinct sources: bad or incompetent professionals (such as Bristol or Alder Hey), widespread variations in cost and treatment for the same condition, self-commercialization and corporate co-optation. Government appeals to bad professionalism, and ineffective and inefficient treatment paid for from the public purse

legitimize the need for ‘enforceable trust’, as professionals, so the rhetoric goes, can clearly not be trusted to regulate themselves. Much of the impetus for reform, in terms of performance management, is driven by the stated necessity of ensuring standardized modes of treatment and patient management (with direct patient input) in order to improve efficiency and effectiveness. They create the conditions of necessity for new enforceable models of trust. Embodied trust is something that government no longer has in medical professions (with one notable exception, GPs). This brings us to Light’s third point, new models of care.

New models of care

The creation of CCGs prioritizes a very specific form of team models of care, with the general practitioner (GP) playing a key role. The emphasis on local provision, brokered by and through CCGs, presents a new model of working whereby the CCGs take on a dominant role in any given locality. Rather than universal provision, there will be different levels of provision within different CCGs depending upon what the CCG decides to prioritize in that locality. One CCG may not offer the same services as a neighbouring CCG. This means that CCGs become the dominant operational unit within the NHS.

This reform can, in part, be read as an extension of GP restratification processes that were initiated by the previous government (Calnan and Gabe, 2009). For example, the restated policy of concentrating the vast majority of clinical resources in primary care, with concomitant ring fencing of funds for CCGs (whereas previously these were more ‘democratically’ dispersed over the PCT, with other professional groupings represented). Under the Health and Social Care Act (2012), CCGs have direct control over the provision of local health care through the deregulation of NHS provision. In effect the GPs’ role is extended to include the governance of private sector providers. Admittedly this happened previously in terms of Independent Sector Treatment Centres (ISTCs) (see Mohan, 2009), but the 2012 legislation extends this line of oversight into non-statutory contexts (Imison et al., 2011). The deregulation of NHS provision, through AQPs also creates greater possibilities for non-physician clinicians to provide statutory care, for example extending the possibilities for nurse-led primary care that were introduced under the previous Labour government. This change demonstrates the continuing shift from a model of state licensure to state regulation – whereby the state underlines its position as buyer, rather than provider, of care. As indicated in the introduction, the initial iteration of the Health and Social Care Bill proposed removing the statutory obligation for the Secretary of State to provide health care, and replacing it only with a duty to promote such care (Pollock and Price, 2011). The proposal was that the Secretary of State for Health was to ‘act with a view to securing the provision of services’, across

three bodies, the NHS Commissioning Board, GP Commissioning Consortia and Local Authorities. This proposal did not survive – Section 1.1(3) of the Act details that the ‘Secretary of State retains ministerial responsibility to parliament for the provision of the health service in England’ (Health and Social Care Act, 2012: 17). Whilst the duty to provide remains, much of the regulatory obligation in regard to that provision has been divested from government and devolved to the three regulatory bodies and the CCGs.

Conclusion

Had the original proposal remained, it would be hard to disagree with Pollock and Price’s argument that it would have signalled the end of the NHS as we know it. Certainly it would have meant the wholesale, marketized deregulation of primary care, such that market competition rather than public provision would have been the dominant motif in the NHS. Indeed this may still be the case, regardless of Section 1.1(3). As Hunter and Williams (2012) argue, it is hard to identify where the public interest lies in such a ‘state as enabler’ scenario.

Processes of deregulation and the role of the market represent, for Hunter and Williams (2012), the dominant political conflict of the 21st century. In this context the Health and Social Care Act can be seen to mark a new articulation of this struggle, with a novel emphasis on the deregulation of public health care provision. Where this novelty lies, in terms of policy, is in the mode of deregulation, such that the deregulated provision still appears as a public good. The devolution of responsibility down to CCGs, as main arbiters of any and all qualified providers, functions to maintain a façade of public provision within a competitive care market which will ‘drive up quality and keep down costs’, to borrow the neo-liberal rhetoric.

Light (2010) argues that new professionalism is couched (in large part) in terms of three central criteria. That these criteria are so dominant within the Health and Social Care Act (2012) serves as testament to the utility of Light’s argument. The Health and Social Care Act is clearly an ideologically motivated piece of government reform, intended to undermine professional dominance, to inculcate private providers (to the exclusion of public providers) into statutory health care, to further inculcate discourses of public distrust in professional groups and to absolve the state of much of its statutory health care obligation. A range of new outcome measures creates external loci of governance, competency and performance management frameworks, which in turn facilitate the deregulation of statutory primary care. In this context, with the buyer dominant, there is a real danger that the NHS becomes little more than a branded franchise operation.

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