Title: **The Reform of the English National Health Service: Professional Dominance, Countervailing Powers and the Buyers' Revolt**

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Abstract: The 2012 English Health and Social Care Act marked a fundamental reform of statutory healthcare in England in ways which elevated the interests of the government over the interests of patients or the professions, and which undermined traditional alliances between professions and patients. Drawing on a countervailing powers framework we present a thematic analysis of parliamentary papers, press releases and other publicly available materials produced across the reform process by four key actors in the healthcare field – the government, medical profession, patients and 'for profit' providers. This analysis explores how the pursuit of sectional interests by these actors may have acted to constrain potential alliances and ultimately contributed to the enactment of the legislation by default. This conclusion has relevance for other Beveridge model healthcare systems undergoing health and social care reform under the auspices of austerity.

Key Words: Beveridge Model, Countervailing Powers, Buyers' Revolt, Health Care Policy, NHS, Professional Dominance

Introduction

Drawing on a countervailing power framework and the notion of a buyers' revolt (Light, 1988, 1998, 2000, 2010) we analyse government-led reforms (culminating in the 2012 Health and Social Care Act) of the so-called Beveridge model English National Health Service (NHS). This is a system predicated on universal access, and based on a single-payer model funded through national taxation. The reform of this provision marked a fundamental shift in how the English NHS was delivered, through the introduction of mixed funding models in that 'for-profit' non-statutory providers now had much more opportunity to deliver statutory healthcare. This marked a significant change in the expectations around provision and promotion of healthcare between citizens and governments, in ways which, it could be argued, negatively impact upon citizens. In this paper we present a socio-historical analysis of the process of political reform. Drawing on a countervailing powers framework we present an analysis which demonstrates how a revolt by payers – the government - facilitated this programme of reform. It accomplished this without provoking a crisis of legitimacy, despite many critical voices both inside and outside the medical profession (Davis and Tallis, 2013, Exworthy *et al.*, 2016). This was achieved through a series of countervailing moves which fostered alliances with key groups, and blocked other key possible alliances. Our emphasis is on how different strategies and rhetorics were deployed to frame the debate and obviate any crisis.

Background to the Reforms: 2012 Health and Social Care Act

Publicly-funded Beveridge model systems are notoriously difficult to reform, firstly, because of their single-payer taxation-based status (fostering the idea of a compact between government and tax payers to provide healthcare) and, secondly, because of this compact, publicly-financed health services tend to be regarded as collectively owned by the population they serve. Any reforms that seek to limit or constrain healthcare or reduce the role of the government in providing healthcare might be construed as breaking a consensus between government and their public, (Powell and Hewitt, 1998).

The reforms contained in the 2012 Health and Social Care Act were not in themselves new or novel. They were the culmination of a long series of processes initiated by the Conservative government in the 1980's and subsequently pursued by successive Conservative and Labour governments (Mohan, 2009). In 2010, the UK Coalition government published a White Paper setting out the tenets of its NHS reforms, which had implications both for healthcare providers and the continuing role of the single-payer state.

The proposed reforms affected both commissioners and providers, suggesting fundamental changes to who could provide NHS services; changes which would significantly impact upon the ailing but prevailing NHS provider monopoly in England. New mixed funding models created opportunities for voluntary sector[i] and for-profit providers to be commissioned to deliver statutory healthcare (Black, 2010, Roland and Rosen, 2011). These were to be achieved through a legislative shift from a statutory obligation 'to *provide* or secure a comprehensive health service' to a statutory 'duty to *promote* a comprehensive health service'

(Pollock and Price, 2011) (italics added); shifting the obligation for providing or commissioning services away from the government (i.e. the Department of Health) and towards the newly established Clinical Commissioning Groups (CCGs), while simultaneously ensuring all healthcare providers (for-profit, voluntary or NHS), were placed in direct competition against each other through *Any Qualified Provider* mechanisms (Long and McLean, 2011). These processes are consistent with a buyers' revolt as characterised by Timmermans and Kolker (2004), creating interdependent yet distinct groups of professions splintered across occupational, financial, organisational, technological and governmental arenas. These changes re-stratify relationships across all healthcare actors. For example, by making CCGs healthcare purchasers, the responsibility for providing a population-level health system now rests with them, creating the possibility for any shortfall in provision to be attributed to bad local management rather than bad central government. Such changes can be broadly characterised as a buyers' revolt (Light, 2010) and the analysis that follows demonstrates how this development facilitated this programme of reform without provoking a crisis of legitimacy.

What is novel about our analysis is that it demonstrates how these reforms were accomplished. It shows how government worked to obviate possible alliances between actors who might have successfully opposed the legislation. This strategy is a documented feature of the buyers' revolt (Timmermans and Kolker, 2004), whereby the governments' strongly articulated buyers' revolt successfully created alliances with patient and private sector actors, whilst simultaneously undermining the possibility of alliances within and between the medical

groupings. We outline the theoretical context of countervailing powers and the buyers' revolt next before presenting our analysis.

Countervailing Powers and Buyers' Revolt

Countervailing powers offers a theoretical context that challenges traditional notions of professional dominance. It is an attempt to offer a means of tracing the strategies and tactics of different groups' attempts to assert dominance over other groups. As such it becomes possible to delineate changing periods and processes of dominance by different actors (e.g. single payers, professionals, medical industrial complex or publics). It provides a comprehensive and dynamic framework that 'can tell us far more than that the medical profession continues to be dominant' (Light, 1991a, 1991b). It offers a way of analysing 'social, economic and political behaviours in a field that is dynamically reshaped over time' (Light, 2014, p. 325), by illuminating the ways that (all) countervailing powers 'construct reality and manipulate symbols to portray their situation favourably and obtain gains'. For example, Vinson, (2016) draws from countervailing powers theory to elaborate the idea of constrained collaboration between physicians and patients as a way of understanding how the profession countervails patient empowerment.

In applying countervailing powers to the 2012 reforms we identify an important explicatory context offered by Light's (1988) notion of the buyers' revolt – characterised as a shift towards health employers and government rearticulating themselves as 'aggressive commissioning experts' (Light 1998). In the US context, this led to the development of selective forms of contracting where the

key decision makers were the payers rather than the providers. These moves towards a dominant commissioning focus were an evident part of the reforms, with the creation of Clinical Commissioning Groups, comprised of GPs but constrained by devolved budgets. The notion of a revolt describes a series of concerted actions, in this case on the part of government and usually formulated around tropes of funding and accountability, intended to undermine professional dominance. Typically, this is accomplished by pushing power and control towards a single-payer, whereby the primacy of government as 'active buyer' (rather than provider) is emphasised. Consequently, government, businesses and the public are constructed as actors who should both demand and expect 'accountability and good value' (Light, 2010) for services purchased from the healthcare profession (the transactional basis of this move is self-evident).

Furthermore, the buyers' revolt is also based on a commitment to reducing levels of statutory expenditure and involvement (Light, 2011). Central to the idea of single-payer systems is their tax-based structure (Roland and Rosen, 2011). In Beveridge model systems this tends to entail instituting new practices around financial and clinical accountability, commissioning and patient-centredness (DH, 2010). These concerted actions can be manifested through sustained efforts to undermine the autonomy and self-regulation that the profession previously enjoyed. In the UK, from self-employed GPs through to state employed hospital doctors, there is a well-established tradition of autonomy and self-regulation (Salter, 2004). The 2012 reforms, structured around new modes of commissioning and regulation (AUTHORS), and increased emphases on patient-centredness and changing professional relations (DH, 2010), attempted to change

those traditions. In a countervailing powers context, Hartley (2002) shows how the imposition of new regulatory regimes work to undermine physician professional dominance by creating new relations or systems of alignment between different actors. Similarly, Light (1997) notes that a key issue in the 1991 NHS market (which he characterises as a failed buyers' revolt) was that the UK Secretary of State remained legally responsible for everything that happened in the NHS. This 'makes him (sic) the chief executive and manager of provision and thus completely hog-tied as a purchaser' (p. 220). This arrangement was markedly not the case in the 2012 reforms, where the Secretary of State's obligation is explicitly identified as one of promotion rather than the previously problematic notion of provision.

In this context, the 2012 Health and Social Care Act can be regarded as an attempt to reduce the reliance of the single-payer (government) on the medical profession (as monopoly provider) to meet public expectations around the availability of free universal healthcare. In this paper we explore the ways in which the concept of a buyers' revolt might usefully be applied to characterise and explain the political success of a series of reforms. This has broader implications for other welfare regimes undergoing similar processes of reform.

Data and Methods

We identify three periods in the legislative process. These are: January 2011 (marking the formal introduction of the legislation to the state legislature); June 2011 (marking a temporary halt to the legislative process); and January 2012 (marking when the legislation was enacted). Within each period we collated

publicly available published materials from parliamentary papers, press releases and other media statements about the legislation issued by the four key groups: the government; the medical profession; patients; and 'for-profit' providers. These documents were identified by tracking the press releases issued by each of the organisations.

There were two inclusion criteria: press releases had to relate to the Health and Social Care Act, and to at least one of the three government priorities stated in the 2010 White Paper: i.e. 1) new forms of accountability; 2) principles of patient-centredness; and 3) innovative and new ways of working that empowered professionals. We defined 'new forms of accountability' as text related to new metrics, based around evidence based medicine, clinical outcome measures, patient outcome measures and patient experience data (DH, 2010). 'Patient-centredness' referred to appeals to a patient led, patient-driven service, characterised by shared decision-making that championed patient and public involvement in order to 'put patients and public first', (DH, 2010, p.12). 'Innovative and new ways of working as empowered professionals' were captured through rhetorics of 'autonomy, accountability and democratic legitimacy', (DH, 2010, p.12). These were predicated on the introduction of effective (and competitive) commissioning processes via the creation of Clinical Commissioning Groups (for a more detailed discussion of these government criteria see AUTHORS).

For the government, we considered a range of Department of Health (DH) documents, parliamentary papers and press releases. For the medical profession

we focused on professional associations e.g. the Royal Colleges belonging to the Academy of Medical Royal Colleges, as other groupings such as the British Medical Association. For patient organisations, we focused on the Patients Association, a national patient charity, independent from government, with over 50 years standing in the field. While not a representative body, it was a vocal and identifiable media presence throughout the reform process. We did not consider national campaigning organisations, as, whilst they were vocal, they were not solely concerned with campaigns about the provision of healthcare. In terms of 'for-profit' providers, we chose the NHS Partners Network and the NHS Confederation. At the time of the reforms, the NHS Partners Network represented the interests of twenty-four non-statutory providers, including Alliance Medical, BUPA UK, Care UK, Capita, Optum, Maximus, and Virgin Care. The NHS Confederation is the membership body for all organisations that commission and provide NHS services, across hospital trusts, ambulance trusts, Clinical Commissioning Groups, foundation trusts, and independent and voluntary sector healthcare organisations. We completed a thematic analysis across the four constituent groups (over 100 press releases and reports specifically related to the healthcare reforms).

There was some imbalance across the published materials, in that the patient groups and 'for-profit' provider groups tended to talk to singular aspects of the legislation (such as patient centredness or new ways of working) whereas government and the profession published materials about all three components. As such there were more documents from the government and the profession included in the analysis. We do not propose an exhaustive analysis of each of the

groups. Rather we are concerned with the public face of these organisations, and how a buyers' revolt framework might help us make sense of what they were trying to accomplish in the ways that they positioned themselves, against other actors. It also needs to be recognised that the public face presented in published material should not be seen as being representative of the views of everyone within each organisation. They are simply the views that were publicly expressed, and which are taken to represent the ways of talking about the reforms that were publicly available for the actors we identified. In this sense they are limited in terms of how representative they may be of the particular groups, but they are taken to be indicative of the dominant framings of public and professional discourse about the reforms. Most of these data are taken from online materials, meaning it is not always possible to assign a page number to the quotations.

The specific examples presented in this paper are indicative of the broader analysis of this data set. We considered the three themes in terms of their standalone presence across the materials and for the ways they were invoked in wider discussions. Coding was completed independently by the two authors and then comparative analysis ensured consensus across the identification and categorisation of themes. We present the analysis chronologically.

FINDINGS

Period One: January 2011 Introduction of the Legislation

The Government

The publication of the Health and Social Care Bill (2011) was accompanied by a press release from the Department of Health entitled 'Patient-centred NHS a step closer to reality', (Department of Health, 2011) in which all of the key proposals were centred around themes of accountability, patient-centredness and new ways of working that empowered professionals. These included how the legislation would 'bring commissioning closer to patients by giving responsibility to GP-led groups' (combining a theme of patient-centred localism e.g. through the patient being closer to the commissioning process, combined with empowered professionals, who would be given more responsibility); how the legislation would 'increase accountability for patients and the public by establishing HealthWatch and local Health and Wellbeing Boards within local councils', (in the UK, a council is the elected administrative body governing a local area). In this example, issues of accountability are coupled to local developments in patient-centredness. HealthWatch were tasked with providing a patient and public involvement focus, with a statutory role in advocating for the needs and concerns of people who used health and social care services. Health and Wellbeing Boards were organised between local authorities and healthcare providers, with the aim of improving integration of local health care, social care, public health and related public services (Davies *et al.*, 2014) – both bodies represent an intended shift which would 'liberate the NHS from political micro-management by supporting all trusts to become foundation trusts' and 'reduce bureaucracy by streamlining arm's-length bodies' (raising issues of accountability, new ways of working and value for money through a promise of reduced bureaucracy). It continued: 'the NHS would be more focused on results

that are meaningful to patients by measuring outcomes such as how successful their treatment was and their quality of life, not just processes like waiting list targets' (examples of accountability, new frameworks and patient-centredness). Furthermore it asserts that bureaucracy would be reduced as 'clinicians would lead the way – GP-led groups will commission services based on what they consider their local patients' need, not on what managers feel the NHS can provide' (themes of accountability and of new ways of working). In turn 'there will be real democratic legitimacy, with local councils and clinicians coming together to shape local services' and 'they will allow the best people to deliver the best care for patients – with those on the front-line in control, not Ministers or bureaucrats' (a combination of new frameworks, patient-centredness and new ways of working). Patient-centredness was identified as the number one priority, to be accomplished through processes that democratised healthcare provision, and reduced levels of direct government (and management), all achieved through a restatement of clinical priorities based on 'what patients need'. The rhetoric of patient-centred care works in the interest of the government because of its ambiguity, i.e. it means different things to different actors. It stakes a claim for the moral high ground and requires those different actors to invest in it without resolving inherent contradictions between what the government might claim is patient-centred and what patients or the profession might think. For the profession, it is impossible not to commit to the idea of patient-centred care. This brings us to consider the response of the profession.

The Medical Profession

There were two main responses to the Bill across the profession: a broad

welcome and critical engagement. To stand against the reforms at this early stage would have been politically inept. The Royal Colleges collectively offered a broad welcome, whereby they 'made clear…support for the principle of the Government's health service reforms, with the emphasis on quality outcomes and the greater engagement of clinicians', (Academy Medical Royal Colleges, 2011) (speaking to new metrics of accountability, but ignoring patient-centredness). The Royal College of General Practitioners, (RCGP, 2011) gave a guarded endorsement of patient-centred localism, calling for 'a much fairer balance between the rights of the individual and the efficiency and effectiveness of the NHS as a whole, as well as taking the broader needs of society into account'. This response identified positive impacts in terms of patient-centredness and good value, and contrasted them with an implied negative impact upon the principle of universal health provision. In a similar vein, the British Medical Association (2011a, 2011b, 2011c) supported greater involvement of clinicians in 'planning and shaping NHS services' (professional empowerment) but described the reforms as a 'massive gamble', arguing possible gains were threatened by forced competition (challenging proposed new ways of working).

There was no concerted countermove against the reforms across the medical groupings. Objections tended more towards reflecting sectional interests rather than a move to protect the principle of universal care.

The Patients

Patient groups were broadly welcoming, suggesting the rhetoric around a patient-centred NHS was effective, echoing the centrality of patient involvement in any

buyers' revolt. Simultaneously, the Patients Association did voice concerns about ensuring clinical decisions were made in the patients' best interest rather than 'what is best for the consortium's bank balance,' (Patients Association, 2011). This combination raised positive endorsement of changes to accountability, whilst also demonstrating a mistrust of the profession and a reticence towards empowered professionals, seen as operating in their own interest rather than the patients. This highlights the utility of a split between the government as promoter and the clinical commissioning groups as provider, as the Patients Association targeted the (frontline) profession with their opprobrium, not the (backgrounded) government.

The Patients Association statement revealed their respective sectional interest. In accepting the idea of patient-centredness, they (wittingly or unwittingly) supported the countervailing move of single-actor dominance on the part of the government. This move worked to align government and patient interests and to increase mistrust between patients and professionals.

'For-Profit' Providers

The NHS Confederation published a pro-reform document two days prior to the publication of the Bill. The document detailed '12 points for policy-makers to bear in mind to minimise the risks associated with moving to a new system' (NHS Confederation, 2011, p. 16) and called for direct dialogue between government and the private sector. Notable amongst the 12 points are the need to 'create a compelling narrative about why the reforms matter in order to engage patients, the public and staff in the enterprise' (*ibid.*), (again aligning the private

sector with the reforming government and perhaps indicating that the utility of patient-centredness was principally as a compelling narrative); the need to 'ensure hospitals operating in a market-based system can reconfigure services and organise multi-faceted specialist care' ; and a statement that policy-makers can only 'recognise the benefits of the market in terms of improving quality and efficiency by creating space for new entrants,' (again, echoing the need for *'real'* competition and for the government to respond to the needs of the private sector). It explicitly asserted that 'this will not happen naturally when, as in the case of the NHS, the size of total markets is not increasing. Closure of existing services will be necessary'; this appears to suggest closure of existing NHS provision to create 'parity' of opportunity for non-NHS providers. By seeking parity of access to existing markets the Confederation is working to countervail the perceived dominance of embedded NHS medical professionals. This is clearly a development of Light's (1997) notion of 'dictated competition'.

In summary, over this first period, initial moves by government provoked a series of either holding or supporting moves from other actors in the field. Private providers wholeheartedly supported the reforms. Patients were drawn into a difficult, perhaps contradictory position – with an obvious appeal of patient-centred care, but coupled to a concern around decreasing levels of healthcare spending. The profession offered a holding position, which kept them 'in the game'. There were clear alliances between government and patient organisations and government and private providers, whilst the profession was largely non-aligned with any other actors in terms of the way the countervailing moves played out.

Period Two: June 2011- A Temporary Halt

It was in this second period that misgivings about the reforms across the profession, patients and private providers provoked a response from government. It decided to temporarily halt the legislative process in April 2011, in what was described as a national 'listening exercise', intended to address concerns about the legislation. In June 2011 a broad-ranging group of health and social care professionals (the so-called Future Forum) was convened. This halt could represent a government response to effective countervailing moves on the part of opponents to the legislation (i.e. some professional groups and some patients), many of whom had publicly raised concerns about the legislation. However, the details of this pressure are not sufficiently recorded in the public domain. We take the four key published criteria that arose from the listening exercise as indicative evidence of manoeuvring, and regard them as the elements that the government had to be seen to be addressing in order to assuage the profession and patient groups. These elements were responses to questions around: 1) 'choice and competition in relation to improving quality'; 2) 'ensuring public accountability and patient involvement'; 3) 'providing new arrangements for education and training'; and 4) 'involving a range of healthcare professions in advising on improving patient care' (Field, 2011). Once again, this 'national listening exercise' was couched in appeals to patient-centredness and citizen engagement, except for point three which suggests a degree of deal-making between government and some elements of the profession to provide a protected status for training and education.

Overall, the pause can be seen to represent a reassertion by government of the necessity of the reform program, couched around narratives of legitimacy and democratic engagement across publics, patients and the profession.

The Government

The Future Forum was tasked by the government with co-ordinating a series of listening events for professions, patients and the public to address concerns about the legislation. Membership of the Forum was by invitation (from government) and comprised forty-four members across four groupings; non-statutory groups, local authorities, healthcare professions, and higher education providers. The largest grouping was healthcare professionals, comprising twenty-six of the forty-four members, with representatives from chief executive officers of NHS trusts, GPs, surgeons and professional associations. Of the forty-four members, only three were 'on record' as having critically engaged with the legislation and none as having opposed it.

The Future Forum made a number of key recommendations; the GP Commissioning Consortia were rebadged Clinical Commissioning Groups (CCGs) and the GP-centric focus was reduced through inclusion of a minimum of two lay-members, alongside a hospital doctor and a nurse (Field, 2011). In addition, there was much more explicit oversight of CCGs in terms of engagement with patients, HealthWatch, clinical senates, and Health and Wellbeing Boards. Clinical senates were instituted across twelve sites in England and comprised of clinicians, patients and other partners. They were tasked with providing non-statutory, independent advice to commissioners and other

stakeholders about population level healthcare decisions (perhaps indicative of a reassertion of population-level provision of healthcare, against a prevailing drive towards localism). Underlying these apparent concessions were a broad range of appeals to the purported democratic legitimacy that patient and public involvement focused activities lent the reforms. These were coupled with measures aimed at assuaging professional concerns; e.g. the incorporation of secondary-care professions (and patients) into the governance arrangements for CCGs.

The Medical Profession

For the profession, a spirit of critical engagement prevailed during this period. The Royal College of General Practitioners (RCGP, 2011a) stated that:

> 'We are reassured that things are moving in the right direction; the emphasis on preserving the principles of the NHS and keeping it free at the point of need; freeing the NHS from political interference; clinical commissioning of local services; and the real focus on reducing health inequalities are to be welcomed. However, we still have a number of outstanding concerns about the potential risks and unexpected consequences of the proposals. We need the Government to reassure us that GPs will be given the freedom and autonomy to lead the decision-making and design of future integrated health systems drawing on the support of other health, social care and third sector services. We support clinician-led commissioning but continue to believe that GPs are best placed to lead this process.'

This extract demonstrates a strong emphasis on sectional interests, though there was also a direct reference to preserving principles of free care based on need, coupled with a strong endorsement of the 'spirit' of the reforms. There is no direct mention of patients. The British Medical Association briefing (BMA, 2011a) also welcomed the Forum report stating: 'The…recommendations address many of the British Medical Association's key concerns…We are hopeful that our "missing" concerns, such as the excessive power of the NHS Commissioning Board over consortia…will be addressed'. This response speaks clearly to their sectional interests, endorsing them whilst offering a clear statement of concern over external influence on clinical activity.

The Patients

The Patients Association (PA) submitted a lengthy memorandum to the Public Bill Committee Debate in the House of Commons stating:

> 'The PA accepts the intention of the Government's Health and Social Care Bill is to put the patient at the heart of the NHS and we support the overall principles of a NHS that is led by clinicians with patients at the centre. We welcome a reduction in bureaucracy if this frees up funding to be reinvested into frontline services. We welcome a focus on patient involvement in services, if this is truly representative of all patients.'

> 'However, our concerns with the current Bill is that it…needs to be delivered against a backdrop of £20 billion savings…Not only do we believe

> this is a near impossible ask of the NHS but it is in danger of having a detrimental effect on patient care and frontline services.' (Patients Association, 2011a).

This statement attempts to de-couple patient-centredness (and the perceived gains it brings for the Patients Association) from concerns about funding. For them, patient-centredness is good, financial constraint is bad. Rather than rejecting the reform program (such is the promise of the post-reform patient-centred NHS), these concerns are couched in terms of the need for a tempered austerity. Financial limitations are viewed as having a negative impact upon patients, i.e. as individualised actors, not as components of a larger healthcare system, again taking us back to Timmermans and Kolker's (2004) characterisation of a buyers' revolt. Consider that an alternative formulation of this context might be that the adverse impact of financial cuts on staffing levels could be even worse in terms of a knock-on effect for patients, regardless of how patient-centred their care might be. This alternative does not feature. The government seems to secure a buy-in from the patients by appearing to valorise those patients' sectional interests and this buy-in lends expediency and legitimacy to the reform process, in turn reasserting the buyers' revolt.

'For-Profit' Providers

The Future Forum did not include any representatives from the independent sector. Their interests seem to be backgrounded during this period, as the government appears to focus on assuaging public and professional concerns about the legitimacy of the reforms. During this time for-profit provider concerns

tend to revolve around making sure their voice is not lost from the discussions.

In summary, this period appears to mark a successful response by government to moves made by various actors against the initial presentation of the Bill. The government offers a number of different manifestations of the legislation that function to accommodate their key objections. It appears that the profession has to an extent protected its sectional interests, resulting in continued endorsement of the legislation (notwithstanding their *realpolitik* need to remain 'at the table'). The patients appear to continue to support the buyers' revolt and the for-profit providers seem to remain concerned about parity of opportunity in terms of access to market.

Period Three: January 2012 – Legislation Passed

In this final period the government pressed ahead with the legislative process. It was a period of escalating professional resistance, but this opposition was largely ineffective.

The Government

Significant challenges came during the Bill's passage through the House of Lords but the government won out after over two thousand amendments (Kmietowicz, 2012) were made to it. These amendments might suggest successful countervailing moves, yet the tone and tenor of the reforms were left largely unchanged, with the central proposals around accountability, patient-centredness and empowered professions remaining, and effected through the

implementation of the new commissioning criteria.

The Medical Profession

As of January 2012 a large number, but not a majority, of the Royal Colleges had collectively called for the Bill to be withdrawn. By March 2012, sixteen (80%) of the Colleges had issued calls for the Bill to be either substantially amended or dropped outright (five wanted the Bill dropped, two balloted their membership over withdrawing support, and nine took or maintained a line of 'critical engagement'). In addition, the Allied Health Professions Federation called for the Bill to be withdrawn, as had the British Medical Association (BMA, 2011a). In this time-period, opposition was formulated around more explicit appeals to altruism, with the reforms represented as working against the best interests of the patient. In calling for the Bill's complete withdrawal, the Royal College of General Practitioners stated '…The College remains concerned that the Bill will cause irreparable damage to patient care and jeopardise the NHS' (RCGP, 2012). They argued that 'competition, and the opening up of our health service to any qualified providers will lead not only to fragmentation of care, but also potentially to a 'two-tier' system with access to care defined by a patient's ability to pay'. This rhetoric inverted the operationalisation of patient-centredness the government had advocated, stating that it countermanded the very foundation of the NHS. In characterising the reforms as the fundamental rejection of the principle of free universal healthcare, the Royal College of General Practitioners sought to challenge the democratic legitimacy of the legislation, by questioning the motives of the single-payer. However, this defence appeared late in the process, it was not foregrounded in the initial response to the legislation, where

the primary emphasis was on sectional interests.

Conversely other Royal Colleges continued to pursue a policy of 'critical engagement', which drew on notions of professional altruism. The Colleges collectively referred to wanting to work with government to ensure the best possible health service for patients (thus utilising patient-centredness but not inverting it as the Royal College of General Practitioners had done).

In sum, many of the constituents of the respective Royal Colleges changed their view of the reforms when it became apparent to them that the new models of professionalism, coupled to new metrics and increased levels of competition, were going to impact negatively on their own sectional (and sub-sectional) interests. This suggests that professional responses throughout the reform process tended to countervail the potential dominance of other medical professional groupings (i.e. each other) rather than the government. In this context the profession was outplayed by this buyers' revolt and failed to countervail the actions of government.

The Patients

The Patients Association moved to describe the Bill as 'misguided, unnecessary and unwanted' (Patients Association, 2012) and identified three key concerns: 'external involvement' in the delivery of care creating excessive competition between providers; the creation of 'GP Commissioning Groups (sic)' which they felt would negatively impact upon the relationship between patients and their doctor; and the assessment that legislation did not offer adequate opportunities

for patient engagement at a local level (i.e. they were not patient-centred enough!). Concerns about marketisation, changing professional relations, and a lack of democratic legitimacy spoke directly to central elements of the critique of the reforms. They explained their change of position by saying that they had these concerns at the outset of the legislative process, but that these had been exacerbated through the different 'incarnations' of the Bill.

The 'for-profit' sector

At the point of enactment of the Bill the NHS Confederation and the NHS Partners Network issued a joint statement in response to an Office of Health Economics report on competition in the NHS. They stated that:

> NHS Confederation chief executive Mike Farrar said: "We believe the NHS should embrace the use of well-managed and intelligent competition. Properly regulated competition and integrated care do not need to be mutually exclusive. Competition should never be an end in itself. Competitive processes need to focus on the improvement of services across the system and ensure that poor providers of care are stamped out. Competition will be a key weapon to help clinical commissioning groups ensure that substandard care is never the only option for their patients. Regulation is key to competition being a success" (National Health Executive, 2012).

> David Worskett, director of the NHS Confederation's NHS

> Partners Network, added: "This report takes an informed and balanced view of the benefits that competition can bring to patients and the standards of NHS care they receive. As the authors of this report rightly point out, competition does not equate to privatisation. Competition is a key means in allowing those responsible for public funds to improve patient care, not the threat which is sometimes suggested. Having a range of providers in healthcare is crucial for promoting innovative treatment and spreading best practice. If the NHS turns its back on competition now, it may hinder its response to the huge demographic and financial challenges it faces in the next 20 years" (*ibid.*).

In this example appeals to patient-centredness (via parity of access) were coupled to the need for integrated care (between health and social care) as a means of ensuring the best standard of patient care. This manifestation worked as a rallying call for the private sector, beseeching government to hold the line against the threat of an unsustainable demographic disaster if the reform agenda was not maintained. The utility of a buyers' revolt is self-evident in terms of how it empowered private sector actors to work in alliance with a reforming state, and how it backgrounded the marketisation of public healthcare through appeals to competition being in the patients' best interest.

In summary, this period marks the conclusion of the state-led buyers' revolt. The profession changed strategy during this time but it appeared to be too little too

late. The patients also rather belatedly started to consider alternative modes of patient-centredness, whilst the 'for profit' providers continued to demand competition be placed at the very centre of NHS provision.

Discussion

We have combined Light's concept of countervailing powers framework with the idea of a buyers' revolt to provide an analytical lens through which to view the processes that facilitated the 2012 reforms of the English NHS. This revolt was accomplished through the simultaneous introduction of more market opportunities for non-statutory providers, coupled with increased patient-centredness (purportedly to increase levels of patient satisfaction) and new modes of professional regulation. Given the ubiquity of similar tropes around these features of healthcare policy across a broad range of western health policy contexts, the 2012 reforms provide a useful roadmap for explicating and characterising these processes as part of wider moves towards the marketisation and privatisation of statutory healthcare.

The countervailing powers approach presents an analytical framework for tracking and explaining the processes of reform by highlighting the ways in which the government asserted itself in the face of the historical dominance of the medical profession. Typically, countervailing powers focusses on the relation between patients and the profession (see Beach 2018, Vinson, 2016), but in this paper we offer insights into countervailing processes involved in a buyers' revolt from the perspective of a Beveridge state single payer moving against a monopoly provider. This approach demonstrates how processes of alliances and

vested interests were played out and through these countervailing moves in order to accomplish a successful buyers' revolt, whereby much of the statutory responsibility for the provision of healthcare was reduced or even removed. Most importantly, this was accomplished without provoking a political crisis of legitimacy. This focus on the legitimacy resonates with Sheid's (2008) assertion that buyers revolts mark a movement from a provider to a buyer driven system of care.

Measures such as these were combined to 'splinter and fracture' the collective bargaining position of the medical profession. *Intra*-sectional interests won out over *inter*-sectional concerns, as the various factions of the medical profession failed to unify against the reforms.

Our analysis demonstrates countervailing moves from within different groups of actors, rather than across different actors. Typically, countervailing powers focuses on moves and counter moves between actors, but our analysis demonstrates countervailing moves within the profession. In this context, sectional rivalry made collective action against the reforms difficult to establish and even harder to maintain. When coupled to vociferous government appeals to patient-centredness, (which played out against this purported professional self-interest) forging any alliances between professions and patients proved difficult. The claimed democratic legitimacy of a patient-centred NHS made any concerted professional/patient alliance difficult?. It is noteworthy that the Royal College of General Practitioners, representing the professionals who stood to gain the most at the outset of the reform process, ended up as the most outspoken critic and

ultimately sought alliances with patients around concerns about universal coverage and access. This would suggest that the RCGP abandoned the pursuit of sectional interests from within the reform process and instead sought a more public strategy (appealing to patients as end-users) in a bid to undermine the patient-centred governmental alliance.

The successful passage of these reforms suggests a prevailing orthodoxy predicated on the articulation of a healthcare funding crisis, enacted through the development or blocking of particular strategic alliances. It is constituted around bottom-line economic arguments of government-invoked austerity, coupled to rhetorics of professional distrust and claims for a concomitant democratic shift towards patient-centred models of care. The application of 'value-for money' principles to the issue of healthcare spending, constituted via patient-centredness and professional control, functioned as a legitimation device for wholescale service reforms. The successful accomplishment of this program was predicated on a reduced level of statutory funding and involvement and increased competition across an expanding number of non-statutory providers. It also involved new models of professional working intended to constrain autonomous professional practice and purchasers and providers tied into new models of accountability. The buyers' revolt clearly was an effective means for government to challenge the dominance of the profession, without provoking a crisis of political legitimacy. The countervailing powers framework offers a very apposite means of interrogating and tracking these changes in the context of neoliberal policy regimes in what looks to be the continuing retrenchment of statutory healthcare provision.

NOTES

[i.] Voluntary sector refers to a range of largely non-profit making community interest companies, charities and other similar organisations involved in the provision of statutory and non-statutory health and social care services.

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