

mt

Confidential Filing

Prime Minister's Meeting with
Professor Margaret Turner - Warwick

PRIME
MINISTER

July 1989

Referred to	Date	Referred to	Date	Referred to	Date	Referred to	Date
<p>PREM 19/2805</p>							

CONFIDENTIAL



subject cc Mark

file 54
Mtg Record

10 DOWNING STREET

LONDON SW1A 2AA

Rev. Mtg with Prof.

From the Private Secretary

31 July 1989

Dear Andy,

PROFESSOR MARGARET TURNER-WARWICK

Thank you for your letter of 28 July providing some briefing material for the Prime Minister's meeting with Professor Turner-Warwick, President of the Royal College of Physicians. That meeting duly took place this morning, and took the form of 50 minutes of friendly but spirited discussion. The Prime Minister was not overly impressed by Professor Turner-Warwick's arguments; she commented afterwards that Professor Turner-Warwick's thinking was dominated by a wish for centralised planning and additional finance. At the end of the meeting Professor Turner-Warwick handed over various bits of documentation, including the Royal College of Physicians' initial response to the White Paper and the latest 'Suggestions and Safeguards' document from the Conference of the Royal Colleges; the package also included the latest version of Professor Turner-Warwick's diagrams, which I am enclosing in case parts of this material are new to the department.

Opening the discussion the Prime Minister said that the White Paper proposals were based on the principle of delegating responsibility for management. With a new generation of managers in place, hospitals now had the capacity to accept this. She hoped that Professor Turner-Warwick agreed with this basic approach. In response Professor Turner-Warwick said that the new NHS management regime post-1984 had got off to a slow start. Of course the aims of the NHS review were fully agreed. But there were some practical issues which led her to have grave reservations; not in the interests of doctors but because of the impact on the interests of patients. She therefore hoped that the Royal Colleges could have an input to contain the risks she foresaw. There were however only one or two 'slightly fundamental' (sic) areas of serious risk where she believed that, with limited adjustment, the right way forward could be identified.

At this point, Professor Turner-Warwick showed the Prime Minister her two diagrams, and explained various features in them. Her concern was that, when two hospitals made competitive bids for business from a District Health Authority, not only would there be a winner but also a loser.

CONFIDENTIAL

Xb

She had no worries at all about the position of the winners, but the losers did concern her. Once they had lost a particular part of their business the resultant alteration of case-mix would have serious consequences for the staff-mix, a trend that would be exacerbated with a movement to flexible pay arrangements. Against a background of generalised staff shortages, the pull of the winning hospitals on the better staff would leave the losers in an increasingly difficult position; the different mixes between hospitals would be very divisive, with the losers being left with lower quality staff and declining standards.

The Prime Minister said she did not accept this analysis. She saw no particular difficulty for a given staff-mix coping perfectly adequately with different case mixes. But the fundamental point about the White Paper system was that hospitals who were initially unsuccessful in bidding for contracts would be obliged to raise their standards; she was confident this process would occur. By contrast Professor Turner-Warwick's approach was a closed box system. Moreover, DHAs would retain a responsibility for the overall provision of hospital care in their areas, and would therefore be obliged to keep an eye on the position of the losers. In so far as there was a problem about the quality of medical staff, this was in large part the responsibility of the Royal Colleges. In visits she had made last year to the Royal College of Surgeons and the Royal College of Physicians she had been much more impressed by the medical audit work being undertaken and planned by the former; she had found her discussion with the Physicians most disappointing. Professor Turner-Warwick said she hoped that would change under her Presidency.

Discussion then moved on to the number of consultant posts. Professor Turner-Warwick said she saw a need for many more orthopaedic surgeons - at least one more per district. The Prime Minister said that additional consultants posts had been provided, but an important contribution to the work load could be achieved by making better use of registrars and junior staff; she also spoke approvingly of what she had heard of the Royal College of Surgeons' scheme for overseas doctors. Professor Turner-Warwick was less impressed with the RCS scheme, which she criticised as unsupervised. She said that the recent approach to providing additional consultants posts had been flawed in gearing the perceived need to the retirement profile of existing consultants, rather than to community need. This had had the effect of squeezing the planned number of hospital doctors at the bottom of the pyramid, a decision that could lead to serious shortage problems in relation to need in 3-4 years' time. The Prime Minister countered that a major difficulty with consultants' output was that waiting lists had been very poorly managed; improving this was a key requirement. Professor Turner-Warwick said the Prime Minister was right to criticise past standards of management in the NHS. But the main problem now was not with senior management, but the inadequacy of the administrative staff and systems that under-pinned them; hospitals found it very difficult to attract staff of the

necessary calibre on the basis of current salary scales.

Professor Turner-Warwick then returned to the issues raised by her diagrams and her worries about losers. She had been told by your department and others that the DHAs would not allow the consequences she feared to come about because of their responsibilities for overall provision in their areas. But she felt bound to say that, although she did not want to harp on about resources, the fact was that DHAs always had been and were likely to continue to be short of money. So they would be forced to make finance-led decisions; although they may not want the consequences she feared to come about, they might be forced to do so. The Prime Minister questioned this; did Professor Turner-Warwick not agree that self-governing hospitals would serve to raise standards and efficiency? The experience with the six experimental hospitals under the Resource Management Initiative (RMI) had been most encouraging, as had the success achieved with specifically targeted use of resources under the waiting lists initiatives. Indeed the logic of Professor Turner-Warwick's arguments could be said to be that all hospitals should become self-governing. Professor Turner-Warwick welcomed the work being done on resource management, but she thought the current experiments were still encountering great difficulties; and there was no doubt that the necessary technology would be very costly.

There followed a brief discussion on the pressures on London hospitals and cross-boundary flow. Professor Turner-Warwick said that cross-boundary flow would work as long as enough money was provided. She added that the problem of shortage of resources in some areas outside London was made worse by the continued operation of a number of smaller hospital units; it would be much more efficient, for example in Brighton, to concentrate the work on fewer sites.

Professor Turner-Warwick then referred to the Suggestions and Safeguards document. She said that the Royal Colleges wanted to be helpful. If their advice was not accepted then so be it. But she believed they had found an alternative way through, namely that DHAs and hospitals in their areas should sit down together and engage on a process of collaborative planning about who would provide what services in a given area. This would produce the best value for money and was "so obviously the best way through". The Prime Minister countered that this was exactly the approach that had been adopted for years past and it had not worked. Professor Turner-Warwick demurred; she felt that the planned system had been working much better recently for example in the North West Thames region of which she had personal experience. Managers were now of a much better quality, but had not yet had sufficient chance to show they could make the system work. Doctors had also learned a lot since the introduction of the management reforms and were now much more aware of the importance of resource issues. The Prime Minister said that some doctors may have changed, but she suspected that many had not, for example given the poor way in which they still managed their waiting lists. Professor Turner-Warwick agreed it was

important to ensure that surgeons were working effectively, but she felt the right way to tackle this was steadily to develop data through the audit system rather than relying on anecdote.

Professor Turner-Warwick then turned to her worries about the implications of the NHS reforms for the future of clinical research. It was crucial that research should be linked to hospital work, and it had to be accepted that research needs would add to clinical costs, for example by requiring some patients to have longer hospital stays. She was concerned that DHA contracts with individual hospitals would break that link, and clinical research would in consequence be the loser. The Prime Minister said she would not accept that; it was of course essential that research work should continue, but the funding systems would be developed to ensure that this happened. In similar vein, Professor Turner-Warwick expressed concern about the implications of hospital contracts for the needs and treatment of the chronically sick; these were likely to be the types of service that would come off particularly badly from competition. The Prime Minister disagreed; obviously the needs of the chronically sick would have to enter into the NHS costing systems, and they must be provided for.

At the end of the meeting Professor Turner-Warwick said that if there was any way in which she could offer to help she would be more than willing. The Prime Minister gave no response other than repeating her thanks for the various bits of documentation.

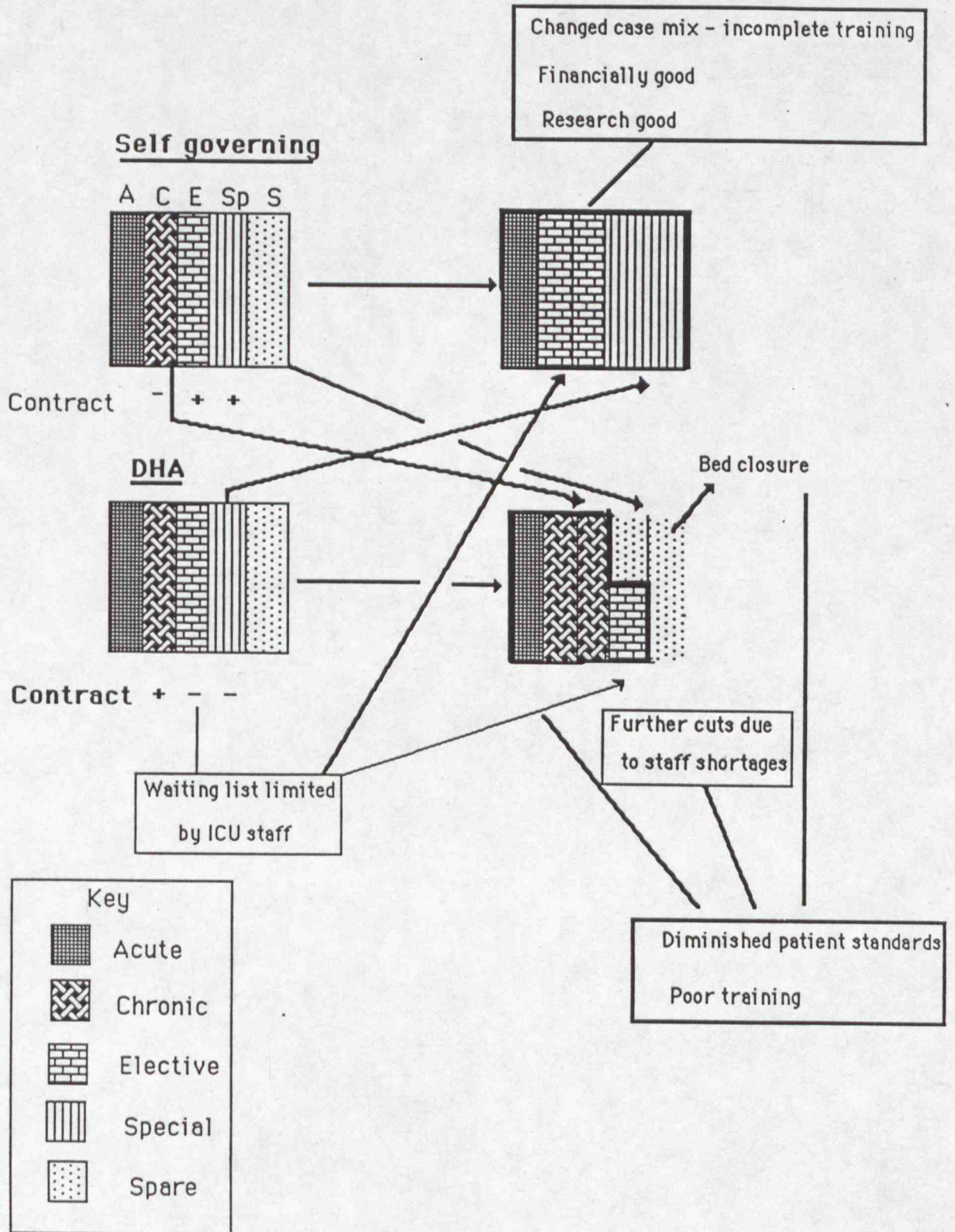
I am copying this letter to Carys Evans (Chief Secretary's Office) and Richard Wilson (Cabinet Office).

Yours,
Pd

PAUL GRAY

Andy McKeon, Esq.,
Department of Health

The effects on patient care and training of Self governing and DHA hospitals in competition



EXPLANATION OF DIAGRAM ENTITLED "The effect on patient care and training of Self-governing and DHA hospitals in competition"

The following serial arguments are set out in diagramatic form.

- 1) The model examined here (and there are many others) looks at two approximately equal sized hospitals within a District, each currently undertaking a range of services, and each with some spare capacity.
- 2) There are many districts within the current health service where this model might apply.
- 3) It is postulated that one becomes self-governing and the other remains under the DHA
- 4) They compete on the basis of contracts for the work they wish to do.
- 5) The self-governing, in particular, will try to attract contracted work in preferred areas and, because there are a finite number of beds, will submit less advantageous contracts for less attractive fields of medicine.
- 6) The DHA must provide these services and the effect on redistribution of case mix is illustrated.
- 7) The model further suggests that the DHA hospital has, as an example, a waiting list for elective surgery. This list is created because there is a shortage of ICU staff.
- 8) The self-governing hospital wishes to take up this work in order to reduce the waiting list in the DHA hospital. It pays the additional ICU staff more and in consequence the DHA hospital is further depleted. Thus, the latter is unable to maintain its existing workload, let alone improve its waiting list. This is so in spite of having empty beds.
- 9) The effects of the altered case mix on both hospitals is illustrated.
- 10) The indirect consequence of all this is unevenness of quality of service to patients and compromised training in both hospitals.

If these effects are to be prevented,

how will this be done?

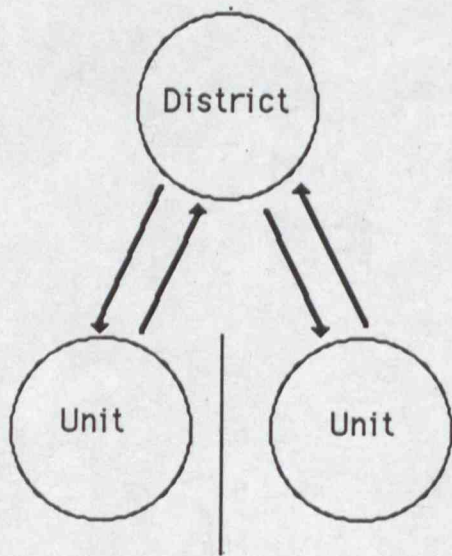
A COMMON RESPONSE TO THE DIAGRAM.

The sequence of events will be prevented because the DHA has control and will demand the services it wishes.

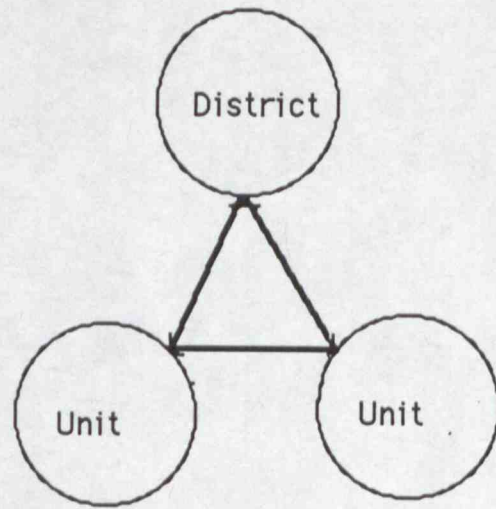
But

- **Does the purchaser have the funds ?**
- **Does the purchaser have the information ?** It depends on whether the DHA actually knows what is necessary. Quality stems from medical , epidemiological and scientific information and this is derived from work of the profession not management ; it is changing and developing all the time.
- **The power of cash limits has overridden quality in the past.**
- **Manpower controls have prevented adequate development of quality to run a consultant led service in the past.**
- **'Specialist' quality tends to be more expensive because of the association with teaching and research. Quality and costs are likely to be in conflict (although of course we would all like the best of all worlds).**
- **If the DHA demands that a hospital does (for example) more routine, then it will have less capacity to do more specialist work. It cannot do both . Hospitals cannot be built to provide facilities on the basis of three year contracts.**

The way through this is for DHA 's and hospitals to get together in planning mode. This is the opposite philosophy to distancing the provider from the purchaser as suggested in the White Paper.



Divisive Competition



Planned Collaboration

PRIME MINISTER

MEETING WITH PROFESSOR MARGARET TURNER-WARWICK

You met Professor Turner-Warwick at Glyndebourne last Saturday and agreed to her request for a meeting. This has now been arranged for next Monday. Her letter following the Glyndebourne meeting is at Flag A.

Professor Turner-Warwick has recently taken over from Sir Raymond Hoffenberg as President of the Royal College of Physicians. You will recall the lunch last year at the RCP with Hoffenberg and his colleagues, which you found less than inspiring.

Since her appointment, Professor Turner-Warwick has been an active lobbyist on behalf of the Royal Colleges, and has played a major role in determining their stance on the NHS review proposals.

Before Monday's meeting you will want to look through the enclosed briefing from the Department of Health. This comprises:

Flag B - covering letter summarising Professor Turner-Warwick's views, which seem to be fully in line with the public stance of the Royal Colleges.

Flag C - the diagram that Professor Turner-Warwick apparently uses as her stock-in-trade and which, on past form, you can expect her to hand to you.

Flag D - more detailed briefing analysing her views, including a letter that Sir Chris France has today written to her following a series of meetings with DoH Ministers and senior officials.

You will see from all this briefing that Professor Turner-Warwick opposes a number of key elements of the NHS review package. I am not sure whether you had gathered this from your talk at Glyndebourne. But it seems clear that your objective on Monday will be to persuade Professor Turner-Warwick of the error of her ways, and seek to persuade her - and hopefully the Royal Colleges in general - to adopt a much more constructive attitude towards the Government's proposals.

JK

Duty Clerk.

f PAUL GRAY

28 July 1989



DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Richmond House, 79 Whitehall, London SW1A 2NS

Telephone 01-210 3000

From the Secretary of State for ~~Social Services~~ Health

Paul Gray Esq
10 Downing Street
LONDON SW1

28 July 1989

Dear Paul

PROFESSOR MARGARET TURNER-WARWICK

You asked for a short note for the Prime Minister's meeting on Monday with Professor Turner-Warwick.

Professor Turner-Warwick is the recently elected President of the Royal College of Physicians. She has played a leading role in determining the Royal Colleges' stance on the NHS Review proposals. She has had separate meetings with the Secretary of State, Permanent Secretary and the Chief Medical Officer to discuss her position. None of these has been fruitful although she tries to be constructive.

Professor Turner-Warwick's views are summed up in the Conference of Medical Royal Colleges' response to the White Paper details of which were published today. This supports

- clinical audit
- the aims of resource management
- the delegation of management to the lowest possible level
- separate funding of cross boundary flows of patients and selective contracts and competition for some surgical procedures.

They oppose

- self-governing hospitals (divisive and would lead to the creation of a two tier system);
- local bargaining on pay and terms and conditions of service for doctors, one of the essential SGH freedoms. They believe this would compromise training arrangements for junior doctors and be divisive;

E.R.

- competition and contracts for most services. They regard most hospital work as core services which must be directly financed by District Management budgets. They believe that competition would lead to fragmentation but their analysis ignores the important purchasing role of the District Health Authorities.

Professor Turner-Warwick believes that the White Paper proposals will damage training and research and also services for chronically ill people despite clear assurances from the Secretary of State. She is likely to claim that several charities for chronically ill and disablement people support her views although their understanding of the White Paper proposals they may not have fully understood.

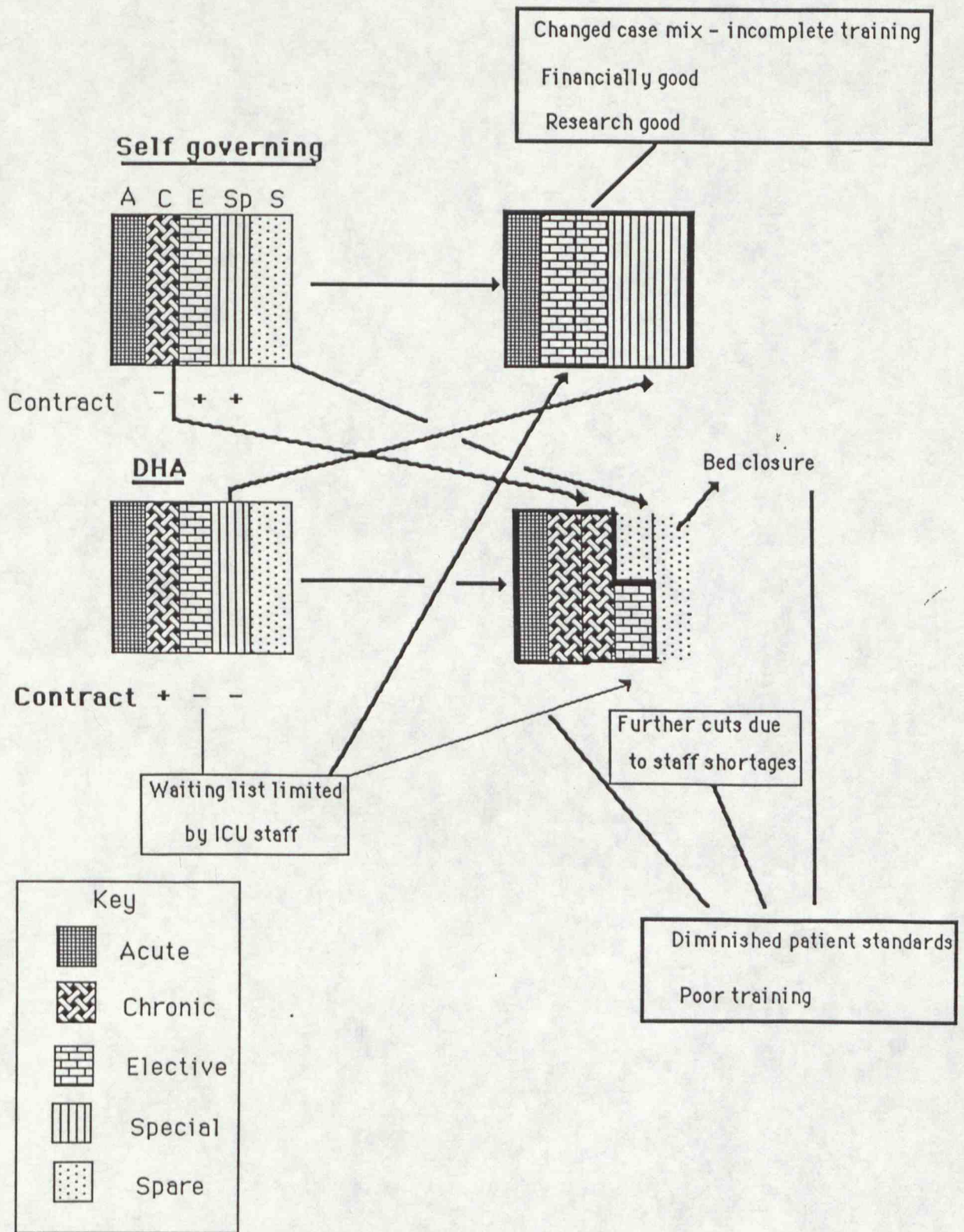
Professor Turner-Warwick is likely to focus attention on her diagram (copy attached) which purports to show the adverse effects which self-governing hospitals and competition will have on patient care. This ignores the fact that DHAs will be purchasers and therefore greatly influence the services which a hospital will provide, that there will be core services which hospitals must provide, that a self-governing hospital's ability to alter pay rates will be constrained by their need to be competitive and that SGHs as well as DHA managed hospitals will want to retain high standards all round including training because this will be an important part of their ability to attract patients. The diagram has been refuted by the Secretary of State and the Permanent Secretary, Sir Christopher France. More detailed briefing is attached.

Jaw

And

A J MCKEON
Principal Private
Secretary

The effects on patient care and training of Self governing and DHA hospitals in competition



EXPLANATION OF DIAGRAM ENTITLED "The effect on patient care and training of Self-governing and DHA hospitals in competition"

The following serial arguments are set out in diagramatic form.

- 1) The model examined here (and there are many others) looks at two approximately equal sized hospitals within a District, each currently undertaking a range of services, and each with some spare capacity.
- 2) There are many districts within the current health service where this model might apply.
- 3) It is postulated that one becomes self-governing and the other remains under the DHA
- 4) They compete on the basis of contracts for the work they wish to do.
- 5) The self-governing, in particular, will try to attract contracted work in preferred areas and, because there are a finite number of beds, will submit less advantageous contracts for less attractive fields of medicine.
- 6) The DHA must provide these services and the effect on redistribution of case mix is illustrated.
- 7) The model further suggests that the DHA hospital has, as an example, a waiting list for elective surgery. This list is created because there is a shortage of ICU staff.
- 8) The self-governing hospital wishes to take up this work in order to reduce the waiting list in the DHA hospital. It pays the additional ICU staff more and in consequence the DHA hospital is further depleted. Thus, the latter is unable to maintain its existing workload, let alone improve its waiting list. This is so in spite of having empty beds.
- 9) The effects of the altered case mix on both hospitals is illustrated.
- 10) The indirect consequence of all this is unevenness of quality of service to patients and compromised training in both hospitals.

If these effects are to be prevented,
how will this be done?

M T-W.

E.A.D

BRIEFING ON THE LETTER OF DR MARGARET TURNER-WARWICK

ABOUT THE POTENTIAL DANGERS OF COMPETITION IN THE NHS

1 Dr Turner-Warwick's analysis of the possible effects of competition on hospital services raises significant issues. The Department of Health is aware of the potential dangers to which she points, and officials are considering ways of ensuring that they can be avoided. Sir Christopher France's response (copy attached at Annex A) deals in detail with the issues she raises.

2 Dr Turner-Warwick's analysis is not wholly complete. It leaves out of consideration the central role of the District Health Authority in:

- a) determining the health care needs of its population;
- b) placing contracts to ensure comprehensive provision of those needs;
- c) deciding what services are "core services" which need to be provided locally.

3 The great majority of the services that all hospitals, whether self-governing or directly managed, wish to sell will be bought by DHAs, whose contracts will ensure that all relevant local health care needs are met. Self-governing hospitals will not, therefore, find it easy to divert large proportions of their activities to potentially more profitable services without running the risk of losing their capacity to respond to DHAs' basic needs.

4 Moreover, self-governing hospitals will be obliged to continue to provide "core services" for DHAs where they are the only or the most appropriate providers, in the same way as directly managed units will have to.

5 Self-governing hospitals will remain part of the NHS and will therefore be expected to maintain their broad obligations to the health service. These obligations include education, training and research. Two of the Department's projects on the implementation of "Working for Patients" are intended to ensure the maintenance of medical education, training and research, and Sir Christopher France's Steering Group on Medical Education is also directly concerned with this issue.



DEPARTMENT OF HEALTH

Richmond House, 79 Whitehall, London SW1A 2NS

Telephone 01-210 5142

From the Permanent Secretary

Sir Christopher France KCB

Dr Margaret Turner Warwick DM PhD DSC(hon)
FRCP (Edin) FRACP FACP FFOM PRCP
Royal College of Physicians
11 St Andrews Place
Regents Park
LONDON NW1 4LE

28th July 1989

Yes Nigel,

Thank you for your letter of 17 July, with its challenging analysis of the possible effects of competition between hospitals on patient care.

If competition were to have the effects that you suggest we would, of course, be very concerned. That is why we are after ways of implementing the Review proposals which will make sure that the results are those Ministers want - higher quality standards, more effectiveness, greater efficiency - rather than the outcome you describe.

Reflecting on your analysis I suggest that it has not taken fully in to account the role of DHAs as purchasing authorities. In paragraph 4 of your note you suggest that hospitals will compete on the basis of contracts "for the work they wish to do". However, a hospital will have no work unless a District offers it a contract. It is the District which must assess the health of its local population, consider what services are required to meet those needs, and place contracts for the services so that acute, long stay and community needs are met. So self-governing hospitals will not thrive if they do not offer Districts, on whom they depend for funding, the services that they want. Further, the provisions about "core" contracts (the services which have to be locally provided) will bind Self Governing Hospitals as much as directly managed units. The requirement to fulfil these core contracts, where necessary, will be written in to their

/constituting ..

E.R.

constituting Orders. The intention is to ensure that Self Governing Hospitals will play their full part in providing the balance of local care which each DHA requires.

I am sure we agree that providers are likely to try to manoeuvre themselves into the most advantageous position. But they will be negotiating with equally determined Districts, and in the real world a hospital will not be able to price its services entirely as it wishes. It will not be viable if it does not meet its actual costs, or if it inflates them excessively through a high wage bill.

Your paper also suggests that hospitals will have finite numbers of beds. The number of beds a hospital brings in to use would depend on the contracts it has arranged and so it will need to be flexible about bringing its facilities in to play. Under the White Paper proposals any hospital will have the opportunity for capital development, provided it can show evidence of having the necessary revenue to support its capital charges and can demonstrate that new or extended contracts will be available to finance increase in capacity. That is to say, it must be satisfying, and earning money from, the Districts which it serves.

What I think we might agree that we need in the new system is for responsible Chairmen and Managers to strike the right balance - to meet local needs in a coherent and comprehensive way and to maintain balanced provision within Units where this is necessary in the light of recruitment, training and research needs. I believe that the outcome you project will turn out to be too pessimistic because it underplays to a significant extent the role of the commissioning District and the "core" responsibilities of SGHs. It is worth contemplating, too, paragraph 4.1 of Working Paper 2 which proposes a major responsibility of RHAs in this area. Their duty is to make sure that hospitals thrive - and to intervene when this looks uncertain.

Thank you again for your letter. I hope you will find my reflections on it at least interesting, and even perhaps persuasive in some respects?

Yours sincerely,
Chris France.

A
127/7



A

ROYAL COLLEGE OF PHYSICIANS

From the President:
Dr Margaret Turner-Warwick
DM PhD DSc(Hon) FRCP(Edin) FRACP FACP FFOM PRCP

11 St Andrews Place
Regents Park
London NW1 4LE

Telephone 01-935 1174
Fax 01-487 5218
Telegrams Medicorum
London NW1

23.7.89

Dear Prime Minister,

It was a particular honour and pleasure to meet you at Sir Ennals Kay's party at Glyndebourne.

I was so pleased to know that you felt an informal meeting might be helpful. I sincerely believe that there are some very important opportunities and ideas within the NHS review and these must be endorsed. We all know there are nevertheless some awkward practical problems to overcome.

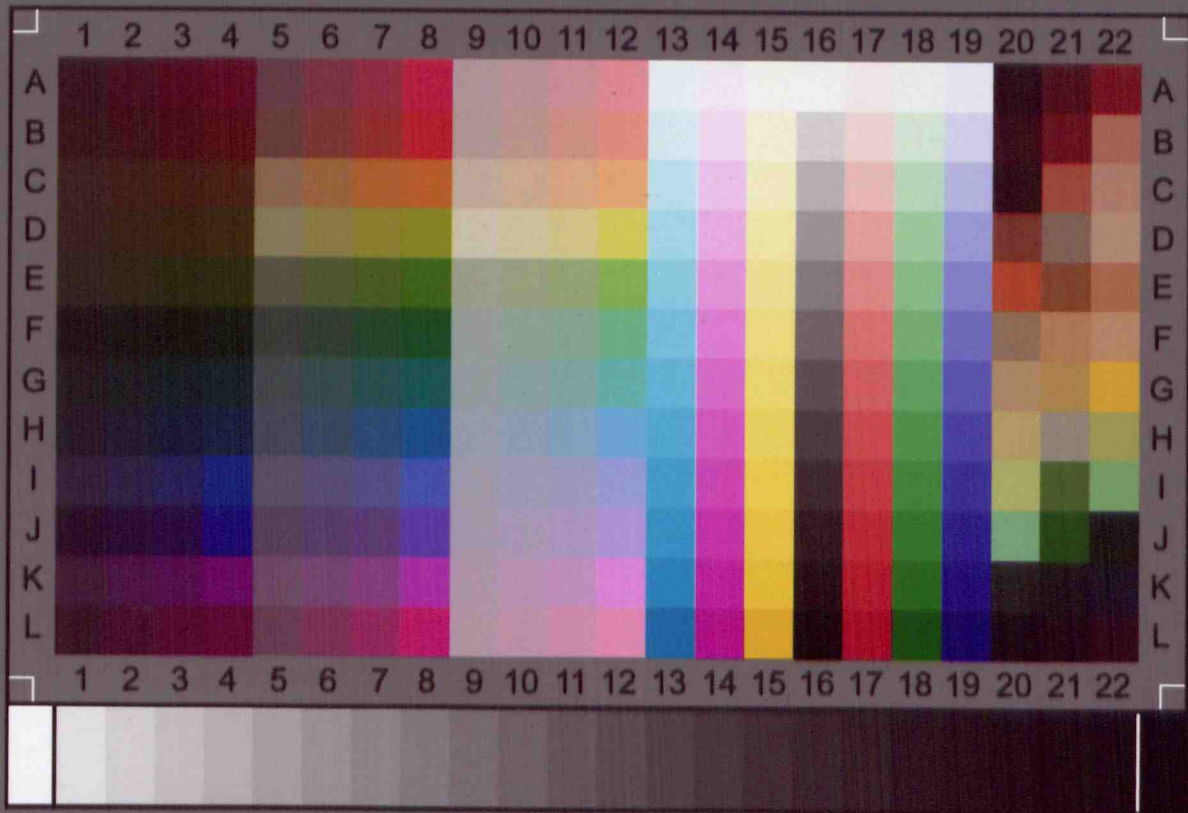
It is sad that so far things
seem to have been conducted more
in an adversarial debate mode, rather
than with serious willingness by all
concerned to listen, understand and
find realistic solutions - especially
when all our hearts and heads should
be in the same place

I am confident that a good
way through can be found.

I am very happy to come back
from holiday whenever it is convenient
for you, and can always be
contacted through the College

Yours very sincerely

Magister John



IT8.7/2-1993

2009:02



IT-8 Target

Printed on Kodak Professional Paper

Charge: R090212