

The Resource
Allocation Working
Party: Origins,
Implementation and
Development, 1974-
1990

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Centre for History in Public Health, London
School of Hygiene and Tropical Medicine
ICBH Witness Seminar Programme

The Resource Allocation Working Party: Origins, Implementation and Development, 1974-1990

Seminar held Thursday 21 November 2013, 2-6 pm, Harry M. Weinrebe Suite, Somerset House East Wing, King's College London

Published by the Institute of Contemporary British History and London School of Hygiene and Tropical Medicine, 2014.

We are grateful to the Wellcome Trust for a grant made to the Centre for History in Public Health at LSHTM, which provided financial support for this meeting. We thank Jenny Walke and Gareth Millward for research assistance.

ISBN: 978-1-910049-06-8

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Chronology

- 1956:** Guillebaud Report – early discussions of health resource allocation.
- 1962:** NHS Hospital Plan: capital allocations rise; discussion of bed:population norms.
- 1970:** Sir Keith Joseph, Secretary of State for Social Services adopts DHSS formula devised under predecessor Richard Crossman for regional resource allocation, based on indicators of population structure, occupied beds, and caseload.
- 1970-75:** Academic papers discuss territorial justice in the NHS: eg. Tudor Hart (1971), *Lancet*; Maynard (1972), Cooper and Culyer (1971), *Social Science and Medicine*, West (1973) *Applied Economics*; Noyce, Snaith & Trickey (1974) *Lancet*; Buxton & Klein (1975), *BMJ*, Gentle & Forsythe (1975), *BMJ*.
- 1974:** **April:** NHS structural reform: 14 Regions, 90 Area Health Boards, 206 Districts.
October: Labour wins General Election. Harold Wilson: Prime Minister, Barbara Castle: Secretary of State for Social Services, David Owen: Minister of State (Health), Brian Abel-Smith: Special Adviser.
- 1975:** **May:** Commissioning of Resource Allocation Working Party (RAWP) to improve upon Crossman Formula.
August: Publication of First Interim Report of the RAWP.
- 1976:** **April:** James Callaghan becomes Prime Minister, David Ennals: Secretary of State,
September: Roland Moyle: Minister of State.
Publication of RAWP Report: *Sharing Resources for Health in England*.
Introduction of Service Increment for Teaching (SIFT) for teaching hospitals.
- 1976-77:** Interim RAWP formula used for distribution; revised formula (final version) used thereafter.
- 1976-80:** Academic papers debate the RAWP formula: eg. Jones and Masterman 1976 *BJPSM*; Carrier (1978) *Year Book of Social Policy* ; Snaith (1978) *JECH*; Knox (1978) *JECH*; Forster (1979) *Jnl Chronic Diseases*; Maynard (1980) *Jnl of Social Policy*.
- 1978:** Appointment of Advisory Group on Resource Allocation (AGRA)
- 1979:** **May:** Conservatives win General Election; Margaret Thatcher: Prime Minister, Patrick Jenkin: Secretary of State for Social Services.
- 1980:** Health Services Act disbands Area Health Authorities (AHAs); main operational powers to District Health Authorities from April 1982.
Publication of the Black Report *Inequalities in Health* sparks controversy.
- 1981:** Introduction of London Market Forces Factor to RAWP. Norman Fowler: Secretary of State for Social Services.

- 1983:** **October:** Griffiths Report: general management in NHS, proposed creation of NHS Management Board.
- 1984:** Proposed changes to RAWP Target Calculations.
- 1985:** Victor Paige appointed first Chairman of the NHS Management Board.
- 1986:** **April:** Norman Fowler requests NHS Management Board review of RAWP. Publication of *Review of the Resource Allocation Working Party Formula*. Research commissioned into morbidity, mortality, deprivation and teaching hospital costs.
- 1988:** **July:** Coopers and Lybrand Report: *Integrated Analysis for the Review of RAWP*. Review of the RAWP Formula: Final Report by the NHS Management Committee. SIFT replaced by Service Increment for Teaching and Research (SIFTR).
- 1989:** NHS White Paper *Working for Patients* proposes to abolish RAWP from April 1990.
- 1990:** *NHS and Community Care Act* establishes internal market.
- 1990-91:** Implementation of revised RAWP formula.

Introduction

Writing in 1972, the pioneer health systems scholar Odin Anderson wondered whether equity could ever be attainable in health policy. Was it perhaps just an 'endless search for the dream'? After all, the track record of Western nations in improving equality of access had not been impressive thus far. Yet the early 1970s was to see a head of steam building in Britain around the question of 'territorial justice' in the NHS. From different quarters commentators began to ask what had become of Aneurin Bevan's initial vision that the NHS would 'universalise the best'? The founding intention had been to abolish the spatial variations that were the legacy of charity and local government, yet despite nationalisation, hierarchical control and new manpower incentives, evidence was mounting that the goal remained elusive. This was the context for the work of the Resource Allocation Working Party (RAWP), which led in 1976 to the introduction of a new formula for distributing NHS funding according to need, and not historical precedent.

Behind the RAWP's dry title and acronym lies a story which speaks to some central issues in the history of the NHS. These range from the high idealism that has inspired the service, to the pragmatic and contentious political questions that always attend reform efforts, to the technical but intellectually absorbing debates about how to achieve the fairest formula for funding health care. The RAWP also deserves historical attention for the insights it can offer into policy-making in the NHS. Different views will be taken on how successful it was, and of course the 'postcode lottery' debate is as live as ever. Yet the RAWP episode instilled in the NHS an enduring policy goal of equality of access to health care for people in equal need. And it did so at a time which was not obviously propitious. It was launched against the backdrop of the mid-70's 'fiscal crisis' of the welfare state, and it hit its stride as power passed to the Thatcher government, whose initial instinct was to favour more decentralisation over national planning. Yet it not only survived but also saw its redistributive effects accelerate through the mid-1980s.

The aim of the Witness Seminar is therefore to examine this important episode in the history of the NHS, through the recollections of some of those involved at the time.

Seminar Transcript: Introductory Remarks

Virginia Preston Good afternoon everybody. My name is Virginia Preston and I would like to welcome you to King's College London this afternoon, on behalf of the Institute of Contemporary British History.

We have been running these seminars at the ICBH since 1986, as they are an invaluable resource for understanding the recent past. We are delighted to be continuing today the various seminars we have held in collaboration with the London School of Hygiene and Tropical Medicine.

Anyone who participates in the seminar should sign a consent form; we are recording the seminar, we will transcribe it and it will be circulated to everybody so that you can take out anything you feel should not be published. The aim is publication, so we do need your consent to do that.

Thank you all very much for coming.

Nick Timmins Thank you very much. I am Nick Timmins, it is my pleasure to chair this thing. Welcome to this seminar on RAWP, its origins, implementation, development, and doubtless, its successes and failures.

RAWP of course is a wonderfully ugly acronym, whose meaning is known to relatively few people; most of them are probably in this room. But it is of course an acronym for WARP: warping existing spending to make it somehow fairer and more just, two words that are laden with value judgements. It is an attempt, both geographically and in terms of the individuals to ensure equality of access to healthcare. To achieve one of Aneurin Bevan's key goals for the NHS: not just that it should lift the shadow of fear from the homes of millions, but that it should universalise and generalise the best.¹ It arrived during Barbara Castle's tenure as Secretary of State for Social Services.² This was a time of immense turmoil and conflict in the National Health Service. There were mighty battles over pay beds and doctors' contracts. Hospitals were picketed; patients were turned away; for the first, and

¹ Aneurin "Nye" Bevan (1897-1960) was Minister for Health (1945-51) and Minister of Labour (1951) in the Attlee governments (1945-51), and the minister responsible for the creation of the National Health Service.

² Barbara Castle (1910-2002) was Secretary of State for Social Services under Harold Wilson between 1974 and 1976, the period during which RAWP was established and reported its initial findings. She had previously been Minister for Overseas Development (1964-65), Minister for Transport (1965-68) and Secretary of State for Employment (1968-70). She was replaced by David Ennals when James Callaghan became Prime Minister, and therefore was not responsible for much of the long-term implementation.

fortunately so far at least, for the last time, doctors went on strike for a period.

When you look back, it is absolutely remarkable how much she and her key ministers in health and social security, one of whom in the shape of Lord Owen is here today, achieved against that background in just two years.

Aside from pay beds and doctors' contracts and the battle about that, which for most politicians would be all consuming, Castle's period also saw either the preparation for or the actual launch of a staggering range of policy and legislation: a whole new state second pension, SERPS; the ground laid for child benefit; a huge and innovative Children's Act; the introduction of a programme budget for the NHS; a priorities document aimed at switching the NHS spending away from the all-consuming acute services, to the Cinderella services such as mental health, a phrase that resonates even today.

There were other changes we could doubtless also touch on, such as the winding-down of the revenue consequences of capital schemes (RCCS), and the battles over the service increment for teaching (SIFT). There cannot have been a more productive two-year period in the DHSS's history,³ and in all that, it is slightly amazing that the time was found, and focus was not lost on, something that was highly technical, had a name that no one could understand, and which on the face of it looked like a boring exercise in number crunching, even if the conclusions were to have big implications for services, staff and patients. So this witness seminar is aimed at getting to the bottom, or somewhere near to the bottom, of all of that.

We have split the day into four sections. Why was the Resources Allocation Working Party set up when it was? Why then? The second is the workings of the Working Party itself, how it was put together, what indicators it used and why, how it did its work, and how it was accepted. The third will be on implementation. The fourth will be an attempt to assess overall, and a glance at its later incarnations.

Before we start, Martin Gorsky is going to provide a 10-minute rapid overview of the historic context, to trigger memories and start to raise the issues.

³ The Department of Health and Social Security. Created in 1968 from a merger of the Ministry of Health and the Ministry of Social Security. It split in 1988 into the Department of Health and the Department of Social Security. Participants may refer generically to "the Department of Health".

Part One – Historical Context

Martin Gorsky Let me add my welcome on behalf of the Centre of History and Public Health from London School of Hygiene and Tropical Medicine. It is very nice to put names to faces, after all the emails. In saying something about the pre-history of RAWP, we certainly need to start with Aneurin Bevan and the ideals for the service. One of the famous quotes is his aim of making society ‘more wholesome, more serene, spiritually healthier if all citizens have access when ill to the best that medical skill can provide’. It is also interesting to refer to two points he made during the second reading of the NHS Bill in 1946, where he alluded to the distribution of health services that the NHS was designed to tackle. He cited the ‘caprice of charity’ in the voluntary hospital system, which was better provided in the well-to-do areas, and less so in the industrial and rural districts. As for local government, although there were some real successes in its hospital provision, in many places, which had inherited their hospitals from the Poor Law, these were ‘...monstrous buildings, a cross between a workhouse and a barracks, and this is because



many places were simply too poor, too small, helpless in these matters.’

Over the last few years, various historians have put a lot of effort into trying to document and assess these sorts of claims that

Bevan had made. I want quickly to sketch out some of the findings to clarify what it was that the NHS actually inherited. The first point, about the voluntary hospitals: there had been no plan around where they were located; how could there be? These were simply groups of philanthropists, and doctors, coming together to found an institution. The roots go back to the mid-18th century and it was London, the wealthy metropolis, which had always had the lead in this sort of provision. As for the funding, it certainly was capricious in some respects, with the big donations and legacies for example. But on the eve of the NHS, it had actually become quite systematic. There were annual subscriptions from businesses and institutions; there were working-class contributory schemes, a sort of workplace payroll deduction for pre-payment. So essentially what this meant was that funding for these hospitals was linked to the economic wealth base and the labour market of their particular area, but not of course to underlying need.

Historians who have run the numbers and tested what sort of variations this led to have found considerable disparities in things like levels of expenditure. This map here shows how it looks if you take the blunt measure of provision, beds per 1,000, and distribution across the British counties in the 1930s. We can do similar sorts of things with utilisation rates, in patients per population etc, and find quite large variations between the big cities.

As for the public sector, local government was providing municipal hospitals as the Poor Law was broken up and the workhouses were starting to be used for that purpose. It was also a period in which local government was coming into things like maternity services, the school medical service and so on. We know that this was a phase of growth, but also a phase in which there were considerable variations between the high and the low spending authorities. Some of this, the latest research is telling us, we should attribute to local choice and local democracy; it was not all completely bound up with the wealth base, or what the rate payers could bear. But the headline finding is, ultimately, that this was what principally determined what local government could do: in the words of the geographer Brian Preston, uneven funding capacity meant 'an endemic structure of inequality'. Central government however, was trying to modify the impact of disparities in rate-borne expenditure by the use of grants-in-aid to local authorities. In the 1920s there was a percentage grant by which they would match what local government would do in

areas like maternity and child welfare, and tuberculosis. However, that tended simply to incentivise those who already had, and not those who were most in need. So that was dropped in 1929 in a big shake-up of rating. A formula block grant was introduced, where you can perhaps see the earliest precursor of RAWP, because it used the population measure, weighted by the proportion of children under five – that was the measure of need – and rateable value and unemployment, the measure of wealth. But the transition was over such a long term and accompanied by large cushioning payments, so that by the time the NHS was being discussed, really very little had been done to moderate the differences in local levels of provision.

Historians have also wondered what this mixed economy of public and private hospitals was doing in terms of addressing the needs of the population. John Mohan has tried a grand correlation exercise, looking at the utilisation rates of the different types of hospital and setting them against indicators of need and wealth. Focusing on 1938, the only year we have data on cross-boundary flows, he produced results that undergirded the argument that Bevan had made. For the voluntary hospitals, there is a positive correlation between use of those and wealth, and negative to need; and vice versa with municipal hospitals.

There is a sort of upside to that: we can say that as the NHS approached, the public sector was filling in the gaps that the voluntary sector had left. But our enthusiasm should be tempered because data on these municipal hospitals tells us that they were more poorly funded. And, particularly in the smaller provincial towns and rural areas, those hospitals which were in transition from workhouses to long-stay institutions were particularly poorly resourced. The 'chronic' patients inhabiting them were '... increasingly left behind ...', in the words of Levene.

As for primary care, the national health insurance system that Lloyd George had introduced from 1911 was by the late-1930s now covering about 50% of the population: the waged, employed, working class. Remuneration to doctors was by capitation, not by fee for service, so that should have provided a mechanism to draw doctors closer to where the population was concentrated. Working against that, however, was the fact that many combined their income from panel practice with private practice as well. So in other words, there was still an incentive in the system for doctors to locate close to where they thought business was better. If we look at some of Martin Powell's data – he is here and one of the people who has led in this field – on doctors per capita in

different places, he has found some distinct variations in the county boroughs, inner cities, in small towns, in the London Boroughs and so on. Again, it seems pretty clear that the level of affluence in the area determined the levels of doctors to population.

What did the NHS set out to do about this? What was Bevan's aim? The NHS did not include a formula for redistribution of hospitals, although there were financial incentives which could be used a lever to get more GPs into the under-doctored areas. But essentially, where the hospitals are concerned, it was the administrative structure that matters. The once independent voluntary hospitals were drawn into regional hospital boards and hospital management committees, where they now sat alongside the ex-local government hospitals. Bevan constituted those boards with people from the voluntary hospitals, from local government, and from amongst the local clinical leadership. Implicit in that, perhaps, was his hope that if these people of good will were on the boards, then gradually the distributional issues would start to be resolved.

So what happened? Here, I will sketch things very briefly as I do not want to steal anyone's thunder, because I am sure people will want to talk about some of these issues.

In the 1950s, we can simply say very little happened. It was a period of tight financial settlements for the service: social policy was more focused at this stage on housing and on education; and the capital programme was really at a very low ebb, even in comparison to the 1930s. There was some movement on consultant appointments, as specialists were appointed further away from the main provincial capitals. But that tended to be within, rather than across, regions. The issue was not really on the academic radar, though there were some early citations of comments, for example by the Acton Trust. And the Guillebaud Report, on which the young Brian Abel-Smith worked as a researcher, also noted the need for some sort of long-term planning for re-allocation of resources, although it noted that at this point this was not really practical.

The first time it did become practical was in the early-1960s, when the money was now starting to flow; Enoch Powell was the Minister of Health and the Hospital Plan was devised. The idea was to create a tier of district general hospitals, and to begin to wind-down and close the old Victorian asylums, workhouses. Policy-makers' goals at this stage were to set standards of appropriate bed to patient norms, which they would like to see

the regions following. We can see here the pursuit of spatial equity via the capital programme, and the consequent shift in revenue income, which, it was assumed, would follow. However, the promise of the Hospital Plan was not quickly delivered, and by the mid-1960s it was clear that implementation would be slow. Public expenditure could not sustain the building rate that was initially anticipated, while the capacity of the building industry also proved insufficient.

That brings us in the late-1960s and early-1970s to the Crossman Formula, devised under Richard Crossman, and taken up by Keith Joseph as Secretary of State in the early-1970s. Here, for the first time, was a partial departure from funding on the basis of historical precedent. The formula was essentially a compromise which relied in part on existing capacity – a calculation based on cost of beds and cases – but in part of need, also including a weighted population calculation. It was at this point, with the Crossman formula starting to be implemented, that the beginnings of an academic debate were heard, a policy discourse gathered pace, and a policy window started to open.

Timmins

Martin, thank you very much. This next session is technically split into the political background and the intellectual background. But I think the two are going to interact so much we will try to take them as we go along. Lord Owen, would you like to set the scene, from a political point of view? Where we were, what was happening, what were the party pressures around this? Where does RAWP fit into Labour's broader programme?

Lord Owen

There was, of course, a very deep seated political drive behind this whole thing, there is no question about that. But seeing some of my old friends and people who were acquainted with it, I hope they will reflect that it was certainly my intention and Brian Abel-Smith's intention that this should be set up in a way that was owned by the department, and that it would have a much longer life than a Labour government, and that it would be felt to be honest and objective within the National Health Service.⁴ Now it was not just retrospectively claiming some sort of great magnanimity; it was also the harsh political realities. We did not have a majority; we came in with two elections in 1974, both of

⁴ Brian Abel-Smith (1926-1996) was an economist who had conducted research into health services and the effects of poverty. In the Labour government of the late 1960s he has been a special adviser at the DHSS under Richard Crossman, a role he reprised under Barbara Castle and David Ennals between 1974 and 1979.

which were inconclusive.⁵ We did not know when we first came in, through the Elephant and Castle, whether or not we would even be there within a year.⁶ We knew we would have to have an election.

Here it is also necessary to remember two or three things. Firstly, that Barbara Castle's priorities were the pension.⁷ Again, actually, her commitment was to have a pension that was agreed across the political parties. Here she was, very like Margaret Thatcher,⁸ hugely ideological, Oxford-trained, first-class brain; very difficult to get her into a rational argument for the first 10 minutes, but if you were still standing, she would listen and change her mind by good argument. Very like Thatcher – quite remarkably similar in many ways, both of them very keen on their appearance, both of them hardworking, never went to a meeting without having done their serious homework and knowledge.

Barbara comes in and the first thing is, she does not totally trust me because I come from a different wing of the party. But my great resource is Brian Abel-Smith, who she trusts absolutely and totally. She is always ready to delegate anything to Owen *and* Abel-Smith. Not always to David Owen, but if the two are working together, she would delegate it. So broadly speaking, it is always delegated.

Then, there was a very crucial choice of – I think I only called him Mr Smith, but I think his name was John⁹ – as the Chairman of this Group, who I think made an absolutely outstanding contribution to it. Now, of course, you are not there in the meetings; you do not always know, but he certainly took the remit that we wanted it to be long-standing and deeply serious and evidence-based. That was the background to it.

Brian Abel-Smith is a very interesting figure. Sally Sheard, who is a social historian at Liverpool, which I used to be the Chancellor

⁵ Two elections were held in 1974. On 28 February, Harold Wilson's Labour Party gained the most seats, but fell 17 short of an overall majority. A minority government was formed after the Conservative Party (led by Edward Heath) failed to convince the Liberal Party to form a coalition. In the 10 October election, Labour secured a majority of 3 seats.

⁶ A colloquialism for the DHSS, whose offices were based in Elephant and Castle.

⁷ Castle had pushed hard for the State Earnings-Related Pension (SERPS). It was believed that the flat-rate pension was not adequate for old people's needs, and that an earnings-related scheme would offer more security. Pension reform had long been a target for the Labour Party, which originally published its plans for such a scheme in 1957, with input from Brian Abel-Smith, Richard Crossman and others. See: Labour Party, *National Superannuation: Labour's Policy for Security in Old Age* (London, 1957); Barbara Castle, *Fighting All the Way* (London, 1994), 468-9.

⁸ Margaret Thatcher (1925-2013) was leader of the Conservative Party 1975-90 and Prime Minister 1979-90. She had taken over from Edward Heath after the 1974 general election defeats. In the Heath government (1970-74) she was the Secretary of State for Education.

⁹ John C C Smith, the chair of RAWP. Throughout the 1950s and 1960s, Smith had held a number of economic posts within the ministries of Social Security and Health.

of, has just produced a book on Brian Abel-Smith; it is coming out fairly soon and unfortunately I cannot be at its launch at the LSE but I have read it and commented on it in a good deal of detail. I think it is an extremely interesting book.¹⁰ He is a fascinating person. He was utterly Labour; to his core he was Labour. Yet, he managed to take into the department an objectivity and differences of view which were really quite remarkable. Peter Townsend,¹¹ who was also then a seminal figure, had all the same commitments, passions and linkages but not the same objectivity. Brian did have it in a quite remarkable way.



That is how I saw the story. I can go through facts and figures, but most of you know this; I wrote about it in this book, *In Sickness and In Power*.¹² It has a virtue of actually being written at the time so there is not too much retrospection in it. Those figures are totally stark: you all know them. A lot of people in the health service, I used to think, thought that the 'R' meant regional.

¹⁰ Sally Sheard, *The Passionate Economist: How Brian Abel-Smith Shaped Global Health and Social Welfare* (Bristol, 2013).

¹¹ Peter Townsend (1928-2009) was professor of social policy and an eminent expert on poverty and welfare. He and Abel-Smith co-wrote the influential *The Poor and the Poorest* (1965). As one of the leading texts in “the rediscovery of poverty”, post-war politicians became aware that the welfare state had not eliminated poverty as had generally been assumed, and that key marginalised groups still required more comprehensive support and services. He had also contributed to Labour’s pension plans in the 1950s.

¹² David Owen, *In Sickness and in Power: Illness in Heads of Government During the Last 100 Years* (London, 2008).

Because we dealt with regional inequalities first, they did not realise that right from day one, it was aimed at misallocation of resources at district level, just as much as region and area.

One other thing I think is worth saying particularly now, and the hellhole we are in, in the health service. When Barbara came in, even before I had agreed to be appointed, I was having a fight about whether I could deal with the doctors as an under-secretary with Harold Wilson.¹³ So I was resisting coming in, and I look back on it rather surprised. I was already captured, actually, because he promised I could do the Children's Act.¹⁴

Barbara said, 'Why don't you stay and listen to this meeting', and the Permanent Secretary [Sir Philip Rogers] came, I think, from the Colonial Service – a very straight and upright and decent man¹⁵ – and said to her, 'Look, within three weeks, it is going to be the appointed day for the reorganised National Health Service.¹⁶ Of course you have the democratic right to stop this reorganisation.' We had been very opposed to it at every level; we thought it was at least one tier too many and there were many aspects of it we disliked. He objectively laid out the case in front of her, and he put the downsides and the upsides of that course of action. He said, 'I have to give you, unfortunately, a very clear recommendation which is not to change it, but if you decide to change it, everybody will loyally follow you'. He did exactly the same over private medicine, I must say. On this occasion, she looked first of all, to me – I thought that was most unfair; I was not even the Minister. – and said, 'What do you think, David?' I said, 'I cannot see any way that we cannot go ahead with this reorganisation without utter chaos'. She agreed, straight away; and from that moment on we just forgot about the arguments about the NHS; whether we liked it or not, we were lumbered with it, and we had to sit with it.

I do think this gave RAWP a very deep commitment. That was about the only thing we could substantively change. We tinkered a little bit with the democratic elements in the community health councils and things like that, but fundamentally we avoided

¹³ Harold Wilson (1916-1995) was leader of the Labour Party 1963-76, and Prime Minister 1964-70 and 1974-76.

¹⁴ The Children Act 1975 reformed the law with regard to adoption and children in care.

¹⁵ Sir Philip Rogers (1910-1990) was a senior civil servant, and Permanent Secretary at the DHSS between 1970 and 1975. He had been responsible for the 1974 re-organisation, and delayed his retirement to help the incoming government implement the changes. He had also spent time with the Colonial Office (1945-64), the Cabinet Office (1964-67) and the Treasury (1967-70).

¹⁶ NHS reform had been passed in 1974 by Sir Keith Joseph, the outgoing Conservative Secretary of State for Social Services. One of its key functions was to create Area Health Authorities as an administrative level between Regional Health Authorities (the old Regional Hospital Boards) and the Districts. Emphasis was placed on new managerial structures to improve cost efficiency.

tinkering with the reorganisation at all. But this was compatible with both our political principles and our beliefs. The opening speaker made reference to the inheritance of the NHS. I am second-to-none in my support for it, but it was appalling, the legacy that we did have on this sort of area. I thought it would be worth giving you these figures: roughly half of the schools in Britain and nearly half of the housing had been built since 1948, but less than a quarter of existing hospitals had been built within the same period. Given the commitment to the NHS, it is extraordinary: 48% of the hospitals in England and Wales were built before 1918; some 6.5% before 1850, whereas only 16% of secondary schools and 42% of primary schools in England and Wales were built prior to 1918. I think that tells you all.

The other issue which I did not mention, which I shall come back to – practical, hard politics, apart from our political, elite position – is we all knew that the strength of the teaching hospitals and the post-graduate hospitals was immense, and we could not defeat it politically. If this came to a straight political battle, we would fail. We had to get respected members of the medical profession and nursing profession, scientists and the members of the various appointed boards, to back us. They had to believe that this was necessary, otherwise London would win, as they had always won before. So that was basically the background.

Timmins

Can I pick up on two points? Your opening remarks: a deep-seated political drive. So you wanted to do it, but what was the political pressure that made this an important issue for the Labour Party?

Owen

In the Labour Party, like all political parties, you have people with no knowledge of the health service at all; and the majority of MPs are in that situation. Then you have a small group of people who are totally dedicated to it; a pretty substantial number of people who had served on different things. One of the best things that Kenneth Robinson ever did for me personally was to ask me as soon as I became an MP, to go on the Charing Cross Hospital board, and I worked through the whole of the planning of Charing Cross and moving out to the new hospital. It was an incredibly helpful investment when I became Minister, and really a wonderful idea, actually, conceptually.¹⁷ I think he was the greatest Minister of Health, actually, the health service has ever

¹⁷ Kenneth Robinson (1911-1996) was Minister of Health under Harold Wilson from 1964 until the re-organisation of the Ministry in 1968.

had. I think he was a very fine man with a deep commitment who rescued general practice, so I have a great deal of time for him. But, nevertheless, I think that that was the background that we were dealing with.

Timmins And you said you were determined that it would be owned by the department. There will be others who can comment on this, but given there had been the Crossman formula and it had been continued by Keith Joseph, who was a Tory, presumably, the department had its own commitment to this before you arrived?¹⁸

Owen I do not know whether they did have a commitment to it; it was pretty much agreed that you could not go on with RCCS.¹⁹ It was generally thought that once you started the new system, it would not run compatibly hand-in-hand. It had not worked very well. I am just looking at what I wrote about RCCS. We thought that it tended to defer consideration of closures, that was one of the things, and it actually had an economic incentive to hold on to hospitals, and not to change them. So, maybe I am wrong about that; the phasing out of the RCCS was completed in 1976-77; it had started before that. I got the feeling – memory plays tricks – but my own instinct was that was pretty broadly accepted in the department; we would wait until we had got serious work from the Resource Allocation Working Party and from that moment, we would not run them in parallel.

Timmins Great; others can come back on that. That is how you saw it when you arrived; I would like to dig back a bit into why it became an issue, which is the intellectual background, the academic background that lay behind what led to RAWP. There were a whole series of papers written by academics, mainly from the early-1970s onwards. Julian Tudor Hart: the inverse care law, which clearly feeds into the arguments behind this.

Julian Tudor Hart Yes, the inverse care law was something that everybody knew but nobody said – that is, nobody operating at the sort of level mainly represented in this room. But everybody knew that poor people had a lot more problems of every kind, including health problems, and that their access to good treatment for these

¹⁸ Sir Keith Joseph (1918-1994) was Secretary of State for Social Services throughout the Heath government, 1970-74. He would later be credited as one of the architects of what became referred to as “Thatcherism”, but had a reputation at this time of being willing to spend money if there was an obvious social benefit.

¹⁹ Revenue Consequences of Capital Schemes. This was an additional revenue allocation given on the presumption that new capital schemes required extra money to maintain. It had come under criticism because it exacerbated the problem of providing more funding to areas which already had received investment, increasing the gap between the “haves” and the “have nots”.

problems was less. All that was lacking was a phrase to sum it up, so I supplied the phrase and the paper did not actually contain any evidence at all. It was a journalistic argument, it was not a scientific paper and it was eight pages long, which was unbelievable. But it swept through *The Lancet*, which is prone to that kind of impulsive... (laughter)

Then about six months later, Alan Snaith provided the evidence which completely validated it, and ever since I have been listening to politicians using the phrase, both people who were progressing with the NHS and people who were undoing it.²⁰ I have always worried that the first clause, that those most in need were least likely to have those needs addressed properly was quoted as though it was a natural law for misfortune, and something that we should regret and wring our hands about.²¹ The second clause was almost never mentioned at all, which was that it was because of a residual effect of the market; it was because we did not have doctors distributed according to need.²² In primary care, we still do not; we still think – ‘think’ is perhaps the wrong word to use – we still assume that equality is what we are after; but illness and misfortune is not equally distributed, and the doctors’ workload reflects how much misfortune there is in the local population. There is about three-times as much misfortune, however you measure it, in poor areas than there is in rich areas. At best, we have the same number of doctors for those people.

Timmins

We will come back to that later.

Tudor Hart

I only heard about RAWP when I left practice to be a visiting professor at Birmingham for a month or two, and everybody was talking about RAWP, but that was as I was moved upwards into the boardrooms. But for GPs, it did not really appear to make any difference.

²⁰ J Noyce, A H Snaith and A J Trickey, ‘Regional variations in the allocation of financial resources to the community health services’, *Lancet* (1974), 554-7. Hart credits this paper for creating ‘a mountain of supporting empirical evidence, which my original paper largely lacked’. Julian Tudor Hart, ‘Commentary: Three decades of the inverse care law’, *British Medical Journal*, 320 (2000), 18-9.

²¹ The opening to Tudor Hart’s summary to the original article reads: ‘The availability of good medical care tends to vary inversely with the need for the population served.’ Originally published as ‘The inverse care law’ in *The Lancet* (27 February 1971), it is available through the Socialist History Association’s website. < <http://www.sochealth.co.uk/resources/public-health-and-wellbeing/poverty-and-inequality/the-inverse-care-law/>

> (accessed 22 July 2014).

²² Ibid. The rest of the summary reads: ‘This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced. The market distribution of medical care is a primitive and historically outdated social form, and any return to it would further exaggerate the maldistribution of medical resources.’



Geoffrey Rivett Very brief point: apart from the academia, the emotional anger that was around. This was a time when regional consultants were irritated by teaching hospital consultants in the south, and in power. It was a time when consultants in the north were irritated by consultants in the south. I was on one occasion going to a meeting in Manchester, and the consultants who had just realised the London was about to get its comeuppance were absolutely over the moon that at long last, the fat cats in the south were going to get it. So among the political factors may well have been internal issues in the medical profession –

Timmins The Hospital Consultants and Specialists Association, set up in opposition to the BMA.²³

Jeremy Hurst For me, I wonder if there were different disciplinary streams in all of this, and I do not remember coming across the inverse care law until somewhat later. As a young health economist in the Department of Health, the paper that had already set out the ground was the one by Cooper and Culyer, published in February 1970 by the BMA – in a volume on health finance by the BMA, so

²³ The Hospital Consultants and Specialists Association was established in 1944 to act as a representative body for specialists during the negotiations for the creation of the National Health Service.

it must have had quite a wide audience.²⁴ It discussed the issue of territorial justice. That was the main subject in Appendix A. Cooper and Culyer attributed that phrase to Bleddyn Davies.²⁵ I have not gone down that route, but Bleddyn Davies must have been writing about territorial justice earlier in the late-1960s. They explicitly recognise standardised mortality as ‘a rough index of need’. They actually correlated expenditure per head across the regions with standardised mortality, and they refer to all of this as a substantial failure on the part of the NHS to achieve social justice, and they wind up by pointing out that more sophisticated planning – they did not use the word, ‘Resource allocations’ – could match need to provision.

Timmins

Peter West, you also wrote about this around about this time?

Peter West

I am a semi-retired independent consultant, these days, but I also do some teaching for King’s College. I got interested in York for two reasons really. One was that York got some money in 1971 to look at the costs of teaching hospitals, so in some ways, that work was a cornerstone of what became SIFT.²⁶ I am only aware that once in my career did something I produce appear to influence policy and, when I look back, it was rather worrying. The report was pages and pages of caveats about trying to understand the cost of teaching hospitals, but we did come up with a central estimate, which was quite high, of the cost of teaching hospitals per student involved. Historically, bear in mind that some of our data included teaching hospitals that did not do any sort of teaching for curious historical reasons. I think all the Cambridge students went to London, for example.

I was working on SIFT crunching numbers with a man called Robin Shannon, who sadly died, and Tony Culyer Then I got interested in the side-line around resource allocation and looking at the hospital revenue allocation formula, and the way in which it did so much, but then stopped because as long as beds were still

²⁴ M H Cooper, A J Culyer, ‘An economic assessment of some aspects of the organisation of the NHS’ in British Medical Association, *Health Services Financing* (London, 1970), 187-250.

²⁵ Bleddyn Davies is professor emeritus at LSE’s Personal Social Services Research Unit, which he founded in 1974. Much of his research has centred on inequality and poverty, especially around long-term and community health care. See for example, Bleddyn Davies, ‘Welfare Departments and Territorial Justice: some implications for the Reform of Local Government’, *Social Policy & Administration*, 3, 4, 1969, 235–252.

²⁶ The York study on teaching hospital costs was central to deliberations over how teaching should be accounted for in the final formula. It was the most comprehensive study available at the time of RAWP. The DHSS had worked with the Institute of Social and Economic Research (now the Centre for Health Economics) to collect and analyse the data that came from it. See M F Drummand and A J Culyer, ‘Financing medical education – interrelationships between medical school and teaching hospital expenditure’, in A J Culyer and K G Wright (eds), *Economic Aspects of Health Services* (London, 1978), 123-140.

in there, it was only ever going to make so much progress towards equality. You cannot achieve equality through a formula with beds, unless you build lots of beds and, as you have already said, there was no real will or money to build lots of beds. So we looked at that formula and found some shortcomings. Then, of course, subsequent to that, Walter Holland got some money to look at RAWP in more detail, and do supporting work, so I worked at that at St Thomas' from 1978 to 1981-82, and others followed on.²⁷ Gwyn Bevan did work on resource allocation.



**Howard
Glennerster**

I was going to pick up that same set of references, but following it up with Bleddyn Davies. Bleddyn Davies, working under Brian, had been working on resource allocation formulae for local authorities from about 1964 onwards and it is from him that the phrase 'territorial justice' comes. His argument was that if you look at the resources that are used by local authorities and you related that to some index of need, these were inversely correlated. He developed need formulae for local authorities which were based on relative utilisation; in other words, the professionals made judgements about the relative needs of people from different age groups and other information you could gather from the local data. That enabled you to produce population need weightings. It was intellectually, exactly the same argument that

²⁷ St Thomas' Hospital is a teaching hospital in Lambeth, central London. The Health Services Research Unit (originally the Department of Clinical Epidemiology and Social Medicine) was based there, which had built a reputation for providing economic evidence for policy makers. Walter Holland, RAWP member and witness in this seminar, was Professor there at this time.

underpinned RAWP.

He had been working with Brian [Abel-Smith] from the date that he was recruited at the department in 1964. Indeed, we competed for the same job; he got it. That is the link, both an intellectual link and a personal one.

West Can I make a quick point there? One of the interesting things was that the local authority work, the rate support grant and so on, turned into something that I recall was a political football, that politicians were always tinkering with; and striking how, by comparison, over most of the period we are talking about, I did not see the same political tinkering with the RAWP process.

Glennerster We see there was some later on.

West There may be some later on, but on the rate support grant, I seem to recall, people are always trying to tilt it towards Labour local authorities or Conservative local authorities. Whereas perhaps the absence of the same political branding of a regional hospital board and area health authorities meant that there was not quite the same lobbying. Obviously you could still identify Labour areas in the health service, but it does not feel like there was the same tinkering with it, like there was with the rate support grant.

Rod Griffiths Back then, I was Secretary to what was then called the Socialist Medical Association, and later I was put on CHC, but I was actually training in public health, which I have done for the rest of my life.²⁸ I think the clever thing that Julian did was call it the 'inverse care law', which made it sound almost mathematical or scientific. If you just looked at the data, what it showed is that where there were more doctors, people were fitter, so you think, 'Medicine works.' I think there were plenty of places that did not have hospitals who wanted one; nothing to do with politics or anything like that. As far as they were concerned, if there was a hospital, you were more likely to live. But prior to the RAWP formula, the way you got a hospital was through a regional health authority capital scheme. So I think all the effort did not go into the political, mathematical calculation. It went into lobbying the RHA to build you a hospital.²⁹ I think the Department of Health and the RHA had some of that mind-set, because what they did when they built a hospital was that they used that to funnel money towards the population, which is what RCCS did. So that

²⁸ Griffiths was chairman of the Association of Community Health Councils for England and Wales, 1979-81. CHCs were established as part of the 1974 re-organisation to act as a link between patients and local health services.

²⁹ RHA – Regional Health Authority. This was the layer of NHS management directly below central government.

was a very simple version: medicine works; where there is more of it, people are fitter. But what he did was, cunningly, made it sound mathematical and turn it into a much more interesting social construct, which we have been grappling with ever since. But I am sure the simple way of looking at it is: 'Medicine works, we will have some please'.

Timmins

It is the power of phrase making: 'inverse care law' is fantastic. In a sense, what we have talked about so far, Walter, is the economic look at this. But there was also an epidemiological angle to this as well.

Walter Holland

I think we got into it, really, because of Brian Abel-Smith. Brian was Chairman of the Advisory Committee to my research unit and he suggested that perhaps it would be worthwhile looking at a fairer way of distributing resources than he had been involved in. It is important to remember that David was a member of the Charing Cross; Brian was a member of the Board of Governors of St Thomas', and he described very well how he used to go, as a representative of St Thomas', to the finance officers at the Department of Health and twist their arms, and got always rather more for St Thomas' than he should have done. But when the Labour Party came into power, he suggested to our unit that perhaps we ought to think about this in terms of an epidemiological study.



We went away and we worked out a scheme whereby we would allocate resources at random to places with a high mortality, or low mortality, and so on. We worked up a very complicated scheme dealing with the individual conditions as well as total conditions, and this was a very short paper that we delivered to the Chief Scientist, who said that it was very interesting, and referred it to David Owen.

David invited Douglas Black and me to come and see him.³⁰ I was told, very distinctly, by David that in no way would he be able to sell a randomised control trial to Parliament, so perhaps I should go away and think again. But he then said he was creating this new working party called the Resource Allocation Working Party and suggested that I should join it. That is how we became involved.

When we came to look at it, one of the major tasks was to try to determine what indicators of morbidity and mortality could be used for the distribution of resources in relation to need. There were two prerequisites. The first was that it needed to be accurate, reproducible, and people would not question it. The second, more important requisite was that it was available – I cannot remember exactly which month – every year, on a particular day, in order that it could influence the following year. It had to be reasonably stable. We went through all the information, like sickness absence, and national insurance, health information studies and so on. We came to the conclusion that the only indicator that really satisfied the criteria of being acceptable of relating to morbidity and be available at a given date of the year was mortality. That was put to the working party and it was accepted.

Rudolf Klein

One of the factors I think was that the re-organisation itself created units, area health authorities, where you could actually identify in a rough and ready way how much money they were getting. Martin Buxton and I together did a very rough and ready exercise, showing that the disparities between area health authorities were much, much greater than those between regions.³¹ I remember having lunch with David Owen, it was at the *Gay Hussar* David, and showing him the preliminary results

³⁰ Sir Douglas Black (1913-2002) was the chief scientist at the DHSS, later the chair of the Royal College of General Physicians. In the late 1970s he was appointed chair of the committee investigating health inequalities known as “The Black Report”. Department of Health and Social Security, *Inequalities in Health: Report of a Research Working Group* (London, 1980). See the witness seminar < <http://history.lshtm.ac.uk/The%20Black%20Report%20and%20the%20Health%20Divide%20%20VB.pdf> >.

³¹ Martin Buxton is professor of health economics at Brunel University, London. With Rudolf Klein, he produced evidence for the *Royal Commission in the National Health Service* (Cmnd 7615). See also M J Buxton, and R E Klein, ‘Distribution of hospital provision: Policy themes and resource variations’, *BMJ* 1 (1975), suppl:345-349.

from our analysis.³² He got quite excited about those. I think it was a good example of how evidence feeds into the policy process; it is when politicians want reinforcement for what they are going to do anyway. (*laughter*)

- Graham Hart** Well, my contribution is not on the intellectual side of it, you will be pleased to know. Lord Owen spoke about getting departmental commitment to the policy and I think when we come to talk later about the next decade, that will become quite a theme.
- I think even at the beginning we should not forget the political pre-1974 election context. For good or ill, the department under Keith Joseph drafted this re organisation which was quite possibly – as Lord Owen said – over elaborate, and we all remember the *Grey Book*?³³ The fact is there was a market for RAWP in this sense: there was, I think, a general recognition that this created a need for better management of the NHS, better coordination, better use of resources, and all the rest of it. Structures were being put in place, quasi scientific work – this was the era when the department first seriously began to talk about planning and instituting a planning system. Now you cannot do all that; you cannot manage the whole thing better without getting at once into these questions, about what resources are needed and where they are needed in order to develop services to the level of quality that you choose to see.
- Timmins** Just going back to an earlier question, the Crossman Formula and Keith Joseph, who stuck with it. I am interested in how far RAWP was a new idea to the department; are you saying there was already a commitment there?
- Hart** I am saying there was a need for it; I am not saying that the department was ready with the answer.
- Timmins** But it recognised the need?
- Hart** I think RAWP was pushing on an open door in that sense, as well as in the other senses.

³² The Gay Hussar is a restaurant specialising in Hungarian cuisine in Soho, central London, which was then a favourite of senior Labour Party members.

³³ Department of Health and Social Security, *Management Arrangements for the Reorganised NHS* (London, 1972). It was so-called for its grey cover and, it was alleged, rather dry content. It was, however, influential in re-organising NHS management structures. See: Martin Gorsky, “‘Searching for the people in charge’: Appraising the 1983 Griffiths NHS management inquiry”, *Medical History*, 57(1) (2013), 87-107; LSHTM witness seminar on the Griffiths Report < <http://history.lshtm.ac.uk/files/2013/07/Griffiths-Inquiry-Witness-Seminar-final-versionsecure.pdf> >.

Malcolm Forsythe Graham has mentioned the planning systems; I will just pick that point up from there. Hospital Management Committees (HMCs) in my region of Southeast Thames were absolutely devoid of any enthusiasm for the health service because they had to beg each year for either revenue or capital. Even if they sold properties, they could not guarantee to get the proceeds, so there was no incentive for them to think innovatively.

When I was in the region, we documented what I can only describe as the, 'Soviet Normative System' of planning for the NHS where everything was prescribed on health circulars. For a district general hospital (DGH) one could work out exactly what the staffing structure was for all disciplines and what the revenue consequences would be. We calculated what implementing the Hospital Plan for South East Thames region would cost.

Fortunately, David Crouch,³⁴ who was the Member of Parliament for Canterbury and a friend of Keith Joseph the Secretary of State for Health, persuaded Keith Joseph to visit for a presentation which demonstrated that to implement the Hospital Plan within the South East Thames region would need three-times as much capital and twice as much revenue as we currently earned as a total region. In other words, it was unaffordable.

We wanted to get the concept of a system of allocating cash fairly without prescribing how the cash should be spent, because we had some very keen Hospital Management Committees and Local Authorities who were very anxious to innovate with different models of care. But the system just did not allow it with this normative planning. So we wanted a resource formula, which gave the capital and revenue out fairly without being told how to spend it.

Gwyn Bevan I am Professor of Policy Analysis at the London School of Economics, and I was in Walter Holland's department; I did quite a lot of work on what [inaudible]. I teach it as a classic case. The report is an extraordinary example of the relationship with a massive problems you have in the data not being good enough, but coming up with a method that was politically acceptable. Just very briefly, a few things: coming back to what Lord Owen was saying, in Aneurin Bevan's speech in 1946, he talked about these three elements of inequality.³⁵ One was finance as a barrier to access; the other was the mal-distribution of GPs; and the third was the mal-distribution of hospitals. They made it free at the

³⁴ Sir David Crouch (1919-1998), Conservative MP for Canterbury, 1966-1987.

³⁵ *Parliamentary Debates* (Commons) 422, 30 April 1946, 43-7.

point of delivery; they introduced the medical practices committee, but they did not do anything about hospitals. So the interesting question is, why did that third thing get left out? I think that is all part of the deal with Lord Moran and the special deal with the Boards of Governors and the teaching hospitals.³⁶ They were, as Walter said, Brian Abel-Smith advising them, enormously successful at carving out capital development revenue, cost of capital schemes, which is why the Crossman Formula could never equalise, because so much was going into RCCS.

On Bleddyn Davis, when Nick Mays and I went to see Brian Abel-Smith when Nick was doing his review of the RAWP formula, Brian traced it back to Bleddyn's paper on territorial justice, and said that this idea appeared in the Labour Party manifesto.³⁷

Timmins

The Labour Party manifesto when?

Bevan

It would be for the 1974 election.³⁸ The point about the SIFT thing – which is the point I claim to be the world expert on – is this extraordinary thing. Ross Tristem, who was on a working party, told me that however you did the sums, the outcome was taking money away from London. So you needed some device to put money back. You needed something that London had a lot of, in relation to population, and you could put a lot of money associated with that. Medical students were the perfect proxy, because there were lots in London, quite disproportionate to population. You needed to come up with some large sum of money you could give to the medical students. RAWP did these estimates of the excess costs of teaching, which bore no relationship to the work Peter did. RAWP's estimates were on a completely different basis and came up with this huge sum for the excess cost of a medical student, which they realised nobody would believe.

So they needed to knock down their estimate of the excess cost per medical student. They obviously thought half was too little, and 100% was too much. Then they realised that if they took Peter's work and captured it in a particular way, they came up

³⁶ Charles Wilson, 1st Baron Moran (1982-1977) was Winston Churchill's personal physician and chair of the Royal College of Physicians at the time the NHS was founded. Moran negotiated a deal with Bevan whereby consultants would only be part-time NHS employees, and so would be able to continue to take on private patients.

³⁷ Nick Mays, currently professor at the London School of Hygiene and Tropical Medicine. He worked with Bevan on the RAWP review of the mid-1980s.

³⁸ In the October 1974 manifesto, Labour pledged to 'reduce regional inequality of standards; put the emphasis on prevention and primary care and give a clear priority to spending on services for the mentally ill and mentally handicapped' (emphasis the editors).

with 75%, which they felt was about the right sort of sum, to give lots of money into London, but not too much.

The other point – I do not know if Sir Graham knows about this – is Lord Owen’s point about needing a long time to do this, and the Labour Party in government having a small minority. I heard that officials went to meet the Conservative opposition, saying, ‘This will take 10-20 years for this to be implemented, and would the Conservative opposition support this if they came into government?’

Mike Gerrard

We have talked an awful lot about resources, but all through the period that led up to the formation of the National Health Service and afterwards, there was a massive amount of money spread around the country in hospitals for mentally handicapped and mentally ill people, in hospitals, for older people, in hospitals for children, and in places where people were being taken care of. Those places, as I think we can all remember, caused a great deal of concern in the 1960s, and one of the main factors that led people to start saying that the National Health Service needs to be reorganised and mental health and various other long-stay provisions need to be incorporated into the general runnings, not just to be in the acute health service.

The point about that is that we have talked quite a lot today about structures; why government did x or y. But government was constrained at all times by the fairly large amount of money that had to be used to resource those hospitals and homes around the country and which were required to be managed in Essex, Cumbria, Cornwall, wherever you happen to be. There had to be money available for what was necessary to keep the traditional health service and the improvement on it running as far as you could; and at the same time, still to modernise the acute side of the health service, and its government and its political connections to other government activities. So I think it is very important to remember that when we talk about acute medicine, we are only talking about one sector of it. At the back of that, all the time, there was a large investment in people and in premises, looking after people who otherwise could not look after themselves.

Timmins

Yes.

Forsythe

In the *Crossman Diaries* there is reference to the fact that Crossman used to meet Dr John Revans from the Wessex Region because that Region had piloted Albert Kushlick’s model of hostel

type care for the then called mentally handicapped (now learning disability), and the real dilemma for the health service was that the local authorities were unwilling to accept any sign of responsibility for their role on the mentally handicapped services.³⁹ So Crossman, in the end, and the Department of Health used their capital and NHS revenue to fund the Wessex mentally handicapped programme. In effect, they took the lead for the other regional hospital boards, following Ely and the other reports, to get the mentally handicapped services out of these huge institutions.⁴⁰ We had 82% of the mentally handicapped beds within the South East Region within Kent as there were no provisions whatsoever in inner-London. Local authorities were not interested. There was also an issue of transferring NHS money to local authorities which led to joint financial arrangements later.

Terri Banks

I thought I ought to speak now because you specifically asked the question, 'Was the progression of programme budgeting relevant?' I think the answer is, actually, no. The programme budget had its origins in American developments. I was dispatched from the Treasury to the department to try to get something going. It was done very separately; it was only accepted I think because the finance people thought it would help negotiate on public expenditure, which indeed it did. But it was a very separate enterprise. When it came to implementation, the priorities document which was based on it, published in 1976, was very much concerned with the balance between the acute services and what is often called the 'Cinderella services'.⁴¹ When RAWP was implemented, there was a double-whammy for the acute services in better off cities; that was a major problem later on.

Timmins

The double-whammy being both RAWP and the shift of money to the 'Cinderella services'?

Banks

Yes, that is right; there was the service redistribution and there was RAWP. But originally they were developed quite separately.

³⁹ Sir John Revans (1911-1988) was Senior Administrative Medical Officer in Wessex from 1957 to 1973, and Regional Medical Officer 1973-76. Albert Kushlick (1932-97) was director of research into mental handicap in Wessex at the time of the RAWP report.

⁴⁰ A scandal at the Ely Hospital in the late 1960s had resulted in an enquiry that showed patients were routinely abused in psychiatric care, causing public outrage. Brian Abel-Smith established the enquiry which was chaired by Geoffrey Howe. See Cmnd 3975.

⁴¹ Services such as long-term care and mental health institutions were called the "Cinderella Services" because they were always a lower priority than acute medicine, despite their worthy claims to resources. See: Department of Health and Social Security. *Priorities for Health and Personal Social Services in England: A Consultative Document* (London, 1976).

Timmins There was one slightly broader question I would like to ask. Some of this was driven by health economics type work; some of it was driven by epidemiological work. Health economics was very young then was it not? It was only just getting going in the late-1960s, early-1970s, along with the movement of epidemiologists into health services research, as opposed to pure epidemiology. Is RAWP an example of these two growing up, these two disciplines growing up and moving across and creating something slightly new?

West From my perspective, I would say it was, although there were only a few pioneers; people like Walter Holland who were prepared to employ economists. I was teaching economics at the time at the University of Sussex, becoming increasingly disillusioned. Finally, towards the end of my career, I was vindicated. Economists have been teaching very complicated mathematical models of perfect competition for donkey's years and increasingly, I thought, 'This is rather silly; the world is not like this'. So I was looking for a career away from conventional university teaching of economics because I had to teach all this stuff, macro and micro economics; I could not just teach health economics. An opportunity came up to go to Walter's unit where I learned an amount of epidemiology. It is interesting that there are now lots of health economists working with and in public health departments. But the NHS has never really embraced health economics, partly perhaps because it is always seen as something the department and NICE⁴² does and so on. But there is very little penetration of health economics into the NHS, in spite of all of these kinds of issues about priority setting and expenditure and other things.

Holland I just wanted to go back one step. Brian Abel-Smith was very proud of the Crossman Formula, which he had helped to devise. We pointed out to him that there is a basic fallacy in that it included utilisation: the fact that his formula, the Crossman Formula, made the differences between regions much worse – and we quoted in particular Bob Logan's studies in Liverpool and Manchester, which had very different levels of resource, showing how, if you had facilities, you would use them.⁴³ Since most of the

⁴² National Institute for Health and Care Excellence. Founded as the National Institute for Clinical Excellence in 1999, its remit is to investigate the cost-effectiveness of treatments and services, with a view to providing equality of treatment across England and Wales.

⁴³ Robert F.L. Logan began this study at the University of Manchester, then moved to the LSHTM in 1967 where he headed the Organisation of Medical Care Unit, and was subsequently Emeritus Professor. The studies were published as R. F. L. Logan, J. S. A. Ashley, R. Klein and D. M. Robson. *The Dynamics of Medical Care: The Liverpool*

new buildings were all within the south, RCCS made the situation even worse in that all the new buildings, increased utilisation, rather than in the north. I forgot that bit of the epidemiology.

John James

I was not going to come in yet, because I was on secondment out of the department at the time of this particular piece of work, but a couple of observations.

One is, I think the creation of the DHSS changed the climate of the traditional Department of Health. I started in Social Security; a lot of people moved across. I think that in social security, we were rather more used to using numbers, outside the operational research and the statistics departments, than perhaps had been the tradition in Health. John Smith epitomises this. He was an extraordinary man in his own right; he grew up in Longbenton, he rose through the ranks of that great factory of people there, and when he came across, it was very obvious that he knew what



Study into the Use of Hospital Resources. Memoir No.14. London: London School of Hygiene and Tropical Medicine, 1972; Gordon Forsyth and Robert F.L. Logan, *Gateway or Dividing Line? A study of hospital out-patients in the 1960s*; London: Nuffield Provincial Hospitals Trust, 1968.

an operational research person was for.⁴⁴ He was an economist and he valued their work. I watched later on, when I moved into Regional Liaison, his understanding and ability on those issues was considerably higher than had been the norm. I think we should not underestimate (a) the slow effect of the creation of a large department; and (b) the movement of people around it. I can also tell you that I think Terri Banks slightly underplays the importance of programme budgeting, which she was responsible for, in affecting attitudes beyond Finance.

⁴⁴ John James adds: Longbenton in Newcastle was the main centre for the records of national insurance and the benefits to which they gave rise, and was where some 10,000 staff were employed in a great clerical factory.

Part Two – The Workings of RAWP

Timmins Those contributions move us beautifully into how the Working Party got set up, and how it worked.

Lis Woods I worked in DHSS at the time, and like John, was an expert from Social Security. I would like to support what he said about the changes in attitude that arose from being one department, even though culturally and to some extent organisationally it stayed two departments until it split up many years later. John Smith was a remarkable leader and, listening to what people have been saying about the extraordinary course that we managed to steer in RAWP, I think that John's leadership helped a lot because he did value the input of the economists, the statisticians, the operational research people; and they were vital to having an evidence-based report. But at the same time, he knew when we were getting over-complicated, and the report itself makes it clear that unnecessary complication is to be avoided at all costs. Earlier on, Peter was talking about the differences between RAWP and rate support grant. I was involved in rate support grant in the Treasury subsequently. It was horrendously much more complicated and one of the reasons why it became not just tempting but actually necessary to fiddle with the results was that it was so complex that you could never predict what kind of results you were going to get by putting in all the various factors. What came out was sometimes plainly flying in the face of common sense. So it was very tempting to introduce 'fudge factors' to make it look more sensible.



RAWP was very transparent, and one reason why it was so transparent was that if you look at the report again, we focus very much on the regional level. That was the level at which you had large enough numbers to work with but chance and local factors did not throw your calculations out. When you look at the recommendations about areas, again they are trying to apply the same principles but it is all surrounded by caveats, that life is actually much more complex than this calculation. Local management has to take account of factors that are not reflected in the formula. That made it a much more resilient and robust system than it would have been if we had been imposing something centrally on very small units, for which the general formula did not work.

The other John Smith memory that I would just like to mention is that he was very clear that we must not aim for perfection; perfection was impossible. What we must and could aim for, and was possible, was *less imperfection*. I think that principle again helped us to do something practicable that worked and lasted.

Timmins

I would just like to ask a question. The actual composition of the Working Party was notable for being very balanced between DH and NHS. I presume that was deliberate on someone's part?

Michael Fairey

I was one of the NHS members of it. There was indeed a balance on the Working Party. That reflected the point that John James just made, that as the department merged health and social security, it became much more open. Indeed, immediately before, the Minister had asked three regional chairmen to go in and examine how the department worked, and that was the task force of which I was secretary, but that was an unprecedented step. The whole idea was we were going to tackle the problem, which was basically to fix the funding of the NHS, the cost of the service you are trying to run. You actually need some people with practical experience who understand what is the impact of what we are trying to do. This is the point that Lis has made, where it is self-evidently going to be a very difficult problem, and there are going to be imperfections. But, at the end of the day, why are you doing it? You are doing it because presumably you want it to happen. That is why it was a good idea, NHS representation, which was put into it, and was vital to its entire work.

Timmins

Whose decision was it? Was that a political decision or a departmental decision? Does anyone know?

- Owen** I think it was mainly John. I certainly signed off on the main NHS members, but I am just looking at it all; certainly going right down to the specialist committees, I do not think I ever saw that. But I certainly saw the overall list.⁴⁵
- Rivett** Most of us were quite in awe of J.C.C. Smith. Let us not forget that at much the same time, a year or two later, he was also running the London Health Planning Consortium, which again was joint between the Department of Health and the regions. Under John's leadership there was much skill and analytical thinking, possibly not appreciated at the time. John was a great man who I do not think has been adequately recognised.
- Owen** Just to add that he was not above subterfuge, because that involvement with London meant that he understood London. At one stage, he and I concocted an arrangement which was to soften some of the blows, but it was remarkable how it was not taken up. That was to offer the tempting task of rationalising the post-graduate hospitals to the London teaching hospitals, which was an opportunity to get hold of some extra money to soften some of this. But most of them completely walked away from it, including St Thomas'. It was completely crazy; I begged these guys to realise this was a helpful gesture towards them.⁴⁶
- Timmins** Could we talk a bit about how the working party did its work? You have already spoken a bit about how the formula was put together, what was looked at. Could someone who was involved volunteer on that? I am not quite sure who to go to. There is some interest in what got stuck in the formula and what did not, and how that was arrived at.
- Woods** Do you want me to comment? As the Secretary, I was on all the sub-groups as well as the main working party. It is a bit difficult to answer that question, because how does any committee do its work? We started from a discussion within the main committee of where we wanted to get to and the work we needed to do to get there. That led us to set up the sub-committees which are recorded in your notes. The sub-committees went into the detail of the work, using a lot of help from both their own attached economists etc and people from outside. Those are just the normal ways that any committee does its work. The sub-committees

⁴⁵ Under the main RAWP committee were three main subgroups concerned with Capital, Revenue, Teaching and Research. For a brief period towards the end of the Working Party, a Sub-group on Criteria of Need was established.

⁴⁶ Walter Holland, who worked at St Thomas' at the time, comments: 'one must remember that in that era general consultants did not value specialists ... [they] were in competition with them'.

looked at the difficulties, tried to find solutions to problems, and brought proposals back to the main committee, which in the end decided whether to run with something or not.



Quite often it became evident that there was an issue that was important, on which evidence was needed. The evidence was just not available. In those cases, we recommended that further work should be done by someone else, and meanwhile, we should focus on things that could be dealt with on the information available. Is that the sort of thing you meant?

Timmins

Yes, sort of. I was quite struck with what you were saying earlier; you looked at the measures that would be available annually, regularly, useably, and you went through the options, and SMR was the best proxy going?⁴⁷

Woods

Yes and you can see within the report that we tested SMRs against various other measures of morbidity and discovered that there were not that many differences. The SMRs were quite robust when you looked at them against other measures, like self-reported sickness.

Hurst

Yes, there were maps in the final RAWP report which showed similar regional patterns, if you look at mortality and limiting long-standing illness, and sickness absence.

Woods

And that fits in with the aim to be as simple as possible. If one measure will do, do not use several.

⁴⁷ Standardised Mortality Ratios are a measure of how many deaths are predicted in a particular area relative to the national populations. They can also be weighted according to the prevalence of certain conditions (and therefore the cost of treating them) through Standardised Mortality Rates. Both measures were key to the final RAWP formula for in-patient care.

West

Just a quick reflection on how RAWP developed compared to later developments. I was involved in two separate things where the people involved were committees where the vested interests were very heavily represented. I wonder whether one of the important things about RAWP was that it was not a committee of 14 regional chairman and 14 regional chief executives. In Northern Ireland, arguing about the formula was a complete nightmare, because everybody knew that there were all these horrible Catholics and Republicans who lived in the western board, and all the big hospitals were in the eastern board, and as I recall, there was a little bit in the southern board, and virtually nothing in the northern board, except coastline. So everything we suggested, every intellectual point we suggested, was immediately rubbished by one side or the other, purely because of the answer it produced. In the same way, we did some work below regional level for Southwest Thames, where a lot of the area or district managers were involved, and they would be constantly on the hunt for anything. I remember the man from Wandsworth was absolutely determined that we should include car ownership as a measure of affluence, because of course, there were great tracts of Wandsworth where better-off young people lived without cars, because there was nowhere to park them. It was quite blatant: car ownership is not a measure of deprivation among people who voluntarily do not have cars. So again, we had this tremendous pressure to put things in.

Perhaps RAWP was successful partly because it was a bit more arms' length and a bit more independent and once one got down either into subordinate countries or subordinate health authorities, it was much harder to find the same kind of local experts to run the committee. Inevitably, the committee became in my view tainted by all the local management.

Griffiths

One thing I am very curious about, and I do not know whether anybody who was deeply involved can say: was the intention to try to remove geographical inequalities or was it just for the health service to just catch up with it? Because we never seem to have tackled things like the Planning Act, which insists on making sure England stays the way it always has been, which is very unequal. We do not tackle the education system, which is not very good at removing inequalities. We do not tackle the media, who have a set of attitudes that are played out every day; the entertainment industry, which reinforces social inequalities, because that is where the jokes are. There are massive engines that

create and maintain inequality in this country. I always thought that what RAWP was doing was just tidying the health service up a bit and give it a bit more money to look after people who were ill. But was it actually trying to do something big? Or was it just catching up? I would be fascinated to know.

Owen

There is absolutely no doubt about that. This was very big. If you explained to somebody what was happening in this department, this department was a power house. It was quite unbelievable what activity was going on, largely by the really serious delegation of power by Barbara. She was a delegator, and that was extremely helpful.

But you have to remember, this was a time when we had mental handicap, mental illness, the report of the regional security units – which is interesting; it is something possibly to discuss a little at one time, where we earmarked resources at the direct suggestion of Rab Butler who chaired it, and you all know the story of how that was completely ignored by the regions – an unbelievable issue. I think this has got to be seen: Cinderella areas were championed at every level for four years. It disappeared towards the end of the Labour government, their nerve lost, and David Ennals – I do not blame him – was placed in a situation under continuous political pressures, and he had a Dover constituency, so it was a different thing.

The aim was this: you also had Douglas Black who would keep coming to my room with documents and papers and explain the scientific significance of these things, and he was pushing. It helped that I was scientifically trained. He had this development which we saw later, a very strong core.

The other thing is, for some – not many young here, actually – but the health service post 1990 is completely different. Parallel hierarchies existed, where you could not really make decisions without there being somebody from the medical or nursing side, with the departmental officials. Again, I helped Sally⁴⁸ to write about this. I keep meeting people who have no idea that, at one time, doctors and nurses with no embarrassment were treated as a core element in the decision making, all through the Godber⁴⁹ years. We must go back to this; we have to somehow get a

⁴⁸ Sally Sheard, *op cit.*

⁴⁹ Sir George Godber (1908-2009) was the government's Chief Medical Officer between 1960 and 1973. He is credited as one of the architects of the NHS.



reappraisal of this and it stemmed from this belief: why are all these doctors in the NHS? Margaret Thatcher said, 'Send them out to do proper work', without any understanding that they had a crucial role. They were a very enlightened group by and large, the public health doctors that were there. There was a good partnership between them and the civil servants in the DHSS. It broke down a bit at the regional level.

Griffiths

My recollection of conversations with you, on behalf of the SMA⁵⁰ in those days, was that we were trying to do something very big, but it seemed to dissipate.

Owen

We spent money we did not have. This is what Barbara Castle – and who was the man who did the finance process, a small man from the Treasury; do you remember? Who was he? They did the negotiations with the Treasury – began with 'E'. He was extremely good at extracting information about money at an official level; and Barbara would go in and fight and the Chief Secretary to the Treasury was by and large pulp in her hands. We did take far too much money; we were facing an acute economic situation and yet, during this period, we increased health spending 1% of GDP. I was ashamed of it later on.

Timmins

At that point we are going to break for tea; we are heading into acceptance and implementation, which will be in the next session. I will come to Howard and Gwyn to open us, after the tea break.

⁵⁰ Socialist Medical Association.

[Break]

Timmins We are heading towards acceptance and implementation but before we do, I promised to bring in Gwyn Bevan and Howard Glennerster, and then I want to go to Jeremy.

Bevan One of the things I teach students, and this is a classic study of policy analysis, is how RAWP's official terms of reference were dry and bureaucratic terms of reference, about applying an objective formula to all levels in the NHS to achieve equity and efficiency. And the first paragraph of the RAWP report was that we are always having to ration healthcare. Then the second has this ringing phrase which is, 'We interpret our terms of reference so there should be equal opportunity of access for those at equal risk'. That seemed to me to become the rallying cry and it comes back to Lord Owen's point that all hell was going to break loose once this report comes out, because London will realise they are going to lose resources.

There were these arguments about excellence versus equity. It seemed to me that by reinterpreting the terms of reference as being that the recommended formula will achieves equity – albeit approximately – it is much better than what we have at the moment. By saying our recommended method will achieve equity of access to the NHS, RAWP staked out the winning political position, because it is very hard to say, 'We want an NHS where we have inequity of access'. I would like to know thoughts. I do not know if it is in John Smith's driving vision to grasp that truth. The other is that they did not do anything at all about efficiency; they threw that to one side, 'We are just going to deal with equity; that is all we can do with resource allocation'. Efficiency would have to be achieved by other policy instruments. I emphasise to my students that once you are part of team with terms of reference, once you get to grips with a problem, you know so much more about the problem than those who set the terms of reference and so you ought to take the opportunity as RAWP did to interpret them so that they make sense given your understanding of the problem. I would like to hear, from those who were there, as to what they felt about it.

Timmins Does anyone want to pick up that point?

- Fairey** Let me try. I do not think it occurred to us at all; it is nothing to do with us. Our job was to sort this funding problem out. Never mind about efficiency; we all know the inefficiencies are difficult to define anyway, so why give us another problem?
- Glennester** This was just to reinforce something that David Owen said about the influence of the medical professions in the decision making process. I was involved once in the Department of Education, where the HMIs were in on every meeting,⁵¹ so that you had a real feel for what was happening at the front end, as it were, by people who knew their stuff in a professional way. It was not just the administrative class of the civil service; it was a really important input. I merely underline that; it was not only true of health, although it was particularly true of health.
- Timmins** Did that have a downside, though, in that you got medical special pleading?
- Owen** Yes, everything has upsides and downsides. I think there was, and I think there was a point where George Godber was probably too powerful, but nevertheless, there was a standard of ethical morality which has completely gone from the medical profession. I do not want to get into current issues, but a lot of what is happening now is the responsibility of the medical profession itself. It ought never to have accepted its professional representation view as reduced. The Royal Colleges should have gone to Margaret Thatcher, and she would have listened to them actually, and said, 'You may think these are bureaucratic doctors; they are essential'. I think most of them do not even know about it. I re-circulated a paper I wrote about it, and Sally Sheard's paper, to the Royal Colleges, and the number of people I met had no idea that this has happened.
- Timmins** Jeremy Hurst, I just wanted you to replay something.
- Hurst** Yes, I just wanted to go back to a question you asked a little time ago about whether this was an important moment for health economists and you mentioned epidemiologists as well. I think that one of the things that strikes me about RAWP and its subsequent bodies is the remarkable way in which it did bring everything together in a sort of satisfying way from the point of view, I would say, of British public administration. That is a political aim and wish, and officials who took up the challenge – and in my case, the analysts: health economists, statisticians and

⁵¹ Officers from Her Majesty's Inspectors of Schools. The Inspectorate monitored standards in education.

operations researchers – in the early days, I think were all rather scrapping with each other, but it brought them together and they were all able to play a part.

There is a little sub-story – I do not know how important this is – about the analysts inside the department doing certain things. For example, in my branch, we did the first version of the market forces factor; we did the work for that, the calculations. Also, liaising with academics outside, such as Peter West. Of course, there is a whole industry out there now of small area analysis and so on. That is quite an important working together: academia and Whitehall.

There are some people unsung, who will probably will not even get mentioned in meetings like this: for example, the research branch in the Department of Health, which was instrumental in finding the money – because they held the purse strings for research – to finance Peter West to do the calculations prior to RAWP, not knowing that RAWP was coming along, on teaching hospitals, which we have already heard about. This came in extremely useful when it came to the need to devise a SIFT allowance.

Timmins

Rudolf, I think you had a question.

Klein

Just a puzzle: how many iterations were there in devising a formula, looking at the implications of the formula of the distribution of resources and revising the formula in the light of the likely impact?

Timmins

Lis, is that one for you?

Woods

It might be but I am afraid I cannot possibly answer that. Can you, because were you...?

Hurst

No because I was not on the main group.

Michael Forsythe

Are you talking about manipulating because you did not like what it showed?

Klein

Yes.

Woods

Oh no. Sorry, I did not understand the underlying question. We did not fiddle the figures. We were always quite honest, and the report is quite honest, in the way it talks about the imperfections of what we did.

Hurst

It has always seemed to me that one of the brilliant ideas – and I do not know if this was invented by the committee or whether it was attributable to one particular individual – is to invent the

distinction between targets, actual allocations, and a pace of change, which was under political control to bring it all together. It seems to me this solves the fundamental conundrum. The conundrum is, if you do move radically in the direction of reversing the inverse care law, you destabilise whole parts of the country, and the institutions in them.



Part Three – Implementation

- Timmins** Which brings us very nicely to acceptance of it. The report lands, so the question presumably is: are you going to do this, Minister?
- Owen** Well, the report landed in three stages, or was it two stages?
- Woods** There was a first report, which was implemented.
- Owen** I was able to write about it in 1976, saying already what we had done in the first report, so it was implemented.
- Timmins** Did you talk to the Conservatives about it, and what their attitude to it would be? You made the point very early on that you wanted this to be stable and lasting. So presumably there is some merit in saying to the other side, 'Are you going to be good?'
- Owen** We were in embattled in the 'Department of Stealth and Total Obscurity' at that time.⁵² As you say, there was one moment when I went to Barbara and said, 'Not even Aneurin Bevan had all parts, the GPs, the junior hospital doctors and the consultants, against him. Barbara, you have to give way.'⁵³ I sound in some parts of her biography as some sort of great whinger, but the basic thing was, she had to toughen up any position you did. That was absolute lock, stock... You would go in with a more extreme position than you wanted to end with because she was bound to toughen it. I think we made a great mistake. I think we have to admit that the geographical full time argument has been able to be won, and the separation of private practice has lost. That was what it was about, and I think we came at it from the point of view of the trade unions and too much from the purity of the issue. But now, no politician would go in and fight for a separation of private health from National Health Service and will accept that it will continue on the same campus. But do not underestimate the real fight, which was about payment by service in the so-called Owen Working Party.⁵⁴ That was a real fight; private practice was a fringe issue. Barbara was prepared at some times to compromise on that, but she would never compromise on her item-by-service payment, and I think

⁵² A nickname for the DHSS based on the lack of transparency and complexity of the work that it did.

⁵³ Castle had been involved in a row with doctors over private practice and pay beds. Labour had committed in their manifesto to reduce pay beds in NHS hospitals, but this caused resentment from those doctors supplementing their income through private practice.

⁵⁴ In 1974-5 Castle and Owen sought to establish a new consultants' contract with remuneration principally by sessional payments; however BMA negotiators proposed a contract based on fee for item of service, a suggestion Castle firmly rejected on 20 December 1974.

she was right. I would have compromised, and I think I would have been wrong. But she saw that as an absolutely central, core question, that you could not let them start being paid on item by service. I think she was utterly right on that.

A certain ideological purity is quite a gift in politics, and she certainly had it. She also believed that guts is everything in politics. If she said it once, she must have said it endless times to me. 'In politics', she said, 'guts is everything'.

Forsythe Just to come back to Rudolf's question, the Department of Health allocated money to regions, and one of the compromises that was reached was that no region got less, year-on-year: the levelling up process. I think your question would have been, perhaps if we could answer it: what happened sub-regionally across the country in terms of their behaviour. I do not think I know how that went.

Owen I have nine regions receiving development allocations, ranging up as much as 4%; five regions being held on no growth.

Martin Powell To follow on from Michael's point, there are two main issues about sub-regions, concerned with sequence and process. Was the idea that once we sorted out the regions, and once regions were equitably funded; then the next stage would be equitably funded sub-regions? Secondly, was the process the same? You had a formula, but if that formula relied on the big numbers, could you implement the formula sub regionally or would it be down to different formula or power struggles or however it moved at a lower level?

Forsythe Certainly from my region's point of view the implication was that we had to. We had to set up a mechanism within the region with the area health authorities to work out what the way forward was. The problem is often in single district area health authorities against multi-district area health authorities. So you have problems of size.

What was the second question?

Powell Was the formula the same? Would it stand up to the small numbers?

Forsythe No, someone said that earlier.

Woods It is actually addressed in the report; it suggests a simplified version of the formula, removing some elements that are plainly not applicable below region; and regions are asked to work with the lower, disaggregated units, to get the right answers. I think I remember we said, 'Build up from districts, but take into account

all the things which need to be added to the formula to make sense of it'.

Fairey

I think the other thing you have to bear in mind is the resource formula came out at the same time as the *Priorities* document. The thing we had to do at regional level, if you wanted to, and which we actually did, was to put the two together and then see what the impact on the region would be. One of the things we had shown, which if you look at the existing distribution is almost self-evident, is that you cannot apply the formula directly; and the smaller the unit, the less applicable it is – in fact it becomes almost inapplicable.

So the answer to your question about what happens as you go to distribute below regional level is it depends what the plan is and where you can get agreement and that is where I think it was a remarkable achievement. Not only did it persuade people that, given where we are, the odds of there being a great deal more money are low, and North East Thames was in quite the worst position, and we had to make the best of a bad job. That therefore involved redistribution and so on, but that is the background to it. RAWP prompts the capacity of the region to do that.

Stephen Davies

I started my career in the NHS at the beginning of the 1990s as an accountant. I was on the receiving end of resource allocation, post the abolition of area health authorities. I was on the receiving end of sub-regional allocations. It was, as people have said, based on using the formula to take it down to district level but there was a lot of – I thought at the time and I still think looking back – very skilful, wise and pragmatic manipulation of the formula at the level of taking account of the districts, certainly in the area I was in which was East Anglia, by the deputy regional finance director. We did not always necessarily like the results, but I think we recognised the soundness of the judgement that was going on, and that it was being done in people's best interests collectively.

Griffiths

I was, from 1982, the DPH in the teaching district of Birmingham.⁵⁵ One of the bigger problems that you run into at a district level is that there is a lot more movement of patients between districts than there is between regions. The regions are big enough that although there is a certain amount of flow into London or Cambridge or somewhere, regions can generally be regarded as complete entities; but within Birmingham, for example, there are huge flows, and they are asymmetric in the

⁵⁵ Director of Public Health.

sense that we found that, for instance, patients coming to regional specialties at the teaching hospital were younger than the ones who stayed at home, because people refer the ones they think most need the high power services. So the formula becomes much more tricky. It took us about four years to sort it out, and in the end, I think the teaching district got another couple of million, simply to recognise the kind of inequality of those folks. I think that a lot of that sort of stuff went on because the hospitals did not necessarily fit exactly the population. So you were in a mess, between allocating to hospitals on the basis of what had gone before, and trying to allocate to population.

When I got there in 1982, I could not even get the hospital activity analysis data, done by my district population. It took me two years to disaggregate all the hospitals in the region – it was not me, it was a research worker I managed to get the money for – and to reassemble it as a district-based population register, so that I could begin to work out some epidemiology about what we were trying to achieve. I think we were probably one of the first districts to do that. We then wrote an annual report and we were one of the first districts to do that, and after that Acheson said we all should. It gives you an idea of how much more complicated it was at a district level because of those flows.

Rivett

One quick anecdote about the special pleading of the chairman of the Northern Regional Hospital Board, coming down to see David Ennals, and saying, 'I cannot go back to my region with a 2.5% growth,' and Ennals saying, 'You will find living in London is very expensive.' To add to Mike's point: the London regions in general were hit three ways. They were, if not losing money, on standstill and it felt as if money was going up north; they were trying to deal with all the scandals in the mental illness and mental handicap hospitals. They were trying to move money out of the centre of London into the shire counties. Net result: if you were a doctor in a central London teaching hospital, you had a pretty good idea that life was not going to get better and would probably get worse for the next 15 years or so, which is no way to start a career.

Timmins

Well, exactly. Which comes to pace of implementation. I was reporting it all around this stage, and I just remember London screaming.

Griffiths

Of course, the media are all sitting in London.

Owen You can argue that was a very good thing; you have much better quality of consultant electing, quite earlier on in their medical career, to go out of London.

Banks I think we are still in the period up to the 1986 Review, and I was involved in this from 1981-86. The first thing I wanted to pick up was exactly the point made about cross-boundary flows. Even at national level, the information was unreliable; it oscillated from year to year; it was always a year out of date; and it was one of the things which could destabilise, even at that level, let alone the sub-regional level.

After 1980, the question was raised, could we do RAWP straight to district from national level. Somebody rushed in and said, 'Our computer capacity can do that.' I remember sitting back and saying, 'That is not the problem.' It really is a matter of local planning, in the end, is it not, at sub-regional level, with all the different things going on?

I did also want to challenge the assumption that no Region ever lost, because we went through the IMF cuts⁵⁶ and we emerged from that actually rather better than we would have done – a lot better than we would have done – without the programme budget, with just enough for medical advance and the ageing of the population. But I think we underestimated what we realised later was the huge interaction between the growing number of old people and the fact that with modern anaesthetics, you were operating on people in their 70s, 80s and 90s, and that was a huge extra pressure from the two combined.

Then we had the Lawson cuts, so right through those 10 years, we were just about holding our own in resource terms.⁵⁷ So with any redistribution, somebody was squeezed. Of course, later on, we would have said, 'That is efficiency savings', and nowadays it is all efficiency savings.

One other point I wanted to make. Geoffrey is raising this question of the double-whammy of the two different documents, but it was also in the context of a total squeeze on health service resources, and that has to be remembered.

Timmins From my memory, there were actual cuts for some of them.

⁵⁶ In September 1976, the UK government was forced to take a loan from the International Monetary Fund, whose conditions included tighter control of public expenditure. In December 1976 the Chancellor of the Exchequer, Denis Healey, announced expenditure cuts of about 20 per cent in the House of Commons.

⁵⁷ Nigel Lawson (b. 1932), Chancellor of the Exchequer 1983-1989. In most of the Lawson years (other than the election year 1987) real expenditure on the NHS increased at a comparatively low level: 1983/4 - 2.2%; 1984/5 - 0.7%; 1985/6 - 1.2%; 1986/7 - 5.5%; 1987/8 - 1.1%.



Bevan

I remember the medical students at St Thomas' wheeling 100 beds over Westminster Bridge to the Houses of Parliament because they were closing wards at St Thomas' Hospital⁵⁸ and it is, as everyone has pointed out, these four pressures. First, there was a freeze in the total spend on the NHS, by not funding the full costs of increases in salaries and wages. Second, there was regional re-allocation. Third there was the priorities document to move resources away from acute services. Fourth there was sub-regional re-allocation. The outcome was that London's big teaching hospitals got hammered.

We did work on the formula in Walter's department. The argument about the way the formula accounted for cross-boundary flows was that this was based on crude estimates of average specialty costs and so did not take account of the more complex cases treated in teaching hospitals. But what we found out was that that was not the problem. The reason why the London teaching districts were being hammered through the application of the formula was because their population had a higher use of services than would be allowed for on a fair basis. In

⁵⁸ Walter Holland, who worked at St Thomas' at the time, comments that there were perhaps only 10-12 beds, not 100. The protest involved medical students and patients in the *Responant* programme, providing respiratory help to those recovering from paralytic polio. They presented a petition to Richard Crossman demanding better funding. Since there were no more than a dozen *Responant* patients at this time at the hospital, this estimate appears more accurate. Source: email correspondence with Walter Holland, Geoffrey Spencer (both of whom worked at St Thomas' at the time) and Stephanie Snow (CHSTM, Manchester).

the London teaching districts, half the population were treated in hospitals in other districts. The problem was that if St Thomas' cut its supply then it would lose income from patients from other districts and patients from its own district could go to other hospitals. This would mean a reduction in its target which would require further cuts in supply, which we described as a 'spiral of decline'. So there was this fundamental problem, about the way the formula accounted for cross-boundary flows. This problem did not matter so much in setting regional targets; it was, however, fundamental in inner-cities such as London.

The final point I would make, which relates to this thing about Thatcher and Lawson's squeeze and the crisis, which is where you cut your teeth in the NHS reforms and the crisis building up to that. I thought that was purely because of the redistribution. If they had not had RAWP, and you just had a level funding throughout the NHS, you would not have had the cuts in London, and the media lapped this up. If you were ever short of a story on the news or the front page of the Evening Standard, just go down to your London teaching hospital, interview a doctor on the ward and, 'There's Mrs Brown, who should have had an operation...' I think the redistribution was a key part of building up to the NHS crisis in 1988-89.

James

What I want to say follows on from what Terri says; sorry if it interrupts the flow. I was responsible for 18 months, at the end of the 1970s, for the discussions with the Treasury about how much money you got for inflation, because this preceded cash limits. That was the point at which inflation was running at about 15%. The impact of any redistribution would be rather dwarfed by the cash addition of that amount, all of which went into established systems. So it was not a good time for redistribution after the impact of the extra for inflation is taken into account.

I am not belittling, however, the extent to which London, in particular, did in fact have all this extra squeezing and I am told – or at least, I have read – that there was an attempt to find a pan-Thames region solution, i.e. to the sub-district allocation process, with the department involved, and that took place in 1979-80. The ultimate result was that not all of them went down the same route. I think there were at least three solutions.

Fairey

I do not remember that particular approach, but the fact is that because of the pressures, you had to have a determined plan about what you were going to do. In the years from 1976, when the process was starting, until I went into the department in 1984,

my region shut 15 hospitals. We opened four, which replaced some of them, but that is the size of the problem that you are looking at. I have to say some of that was not always proceeded with terribly carefully. There was a lot of noise, but you had to do it and it worked.



Hart

Picking up on what colleagues have said, Lord Owen, right at the beginning, was asked about departmental commitment to all this, and the political approach to it. I came into this in 1983 or 1984, and I was really surprised I have to say, and pleased, at the way in which officials and ministers – Norman Fowler and Ken Clarke – stuck to the policy, and they took a lot of stick for it. It may have helped a bit that they were both Midlands MPs rather than London MPs, but I can honestly say that there was a real commitment. Terri is a very tough lady and she reminded them from time-to-time what we were supposed to be doing, and they did accept it in the end. It was a bit like how you described Barbara: you had to talk through it, but it went on.

The redistribution went on. You can see from the graph, pretty consistently, right through the early days, at a time when it was politically very questionable. I think it did play a bit of a part – not as big as you might think – in the great funding crisis of 1987 which as I recall, really took off in Birmingham: Birmingham Children's Hospital and all that stuff. This put a lot of heat on people and what happened in the end – I cannot quote chapter and verse on this and someone would have to look at the papers – but it is certainly true that voices were being heard from Number

10 and other political directions, quite insistently, through the mid-1980s, which found their way into Working for Patients in the end, saying, 'What is this, this instrument of torture, RAWP, which is inflicting pain on Conservative constituencies and giving money to Labour-voting constituencies in the north of England?' It was not an obvious policy you could make stick and carry through with. Of course, in the end, it had to be looked at again. Perhaps you want to come on in due course to that.

Timmins

Yes, we do. Just one comment on the 1987 crisis. Beds were closing all over the country; it was not just London; everywhere, even in the 'gaining' regions, things were being closed by the thousands: 4,000 beds shut – an unbelievable number.

West

A couple of the numbers I always remember from the Hospital Plan, which came out in 1974, was that some of the research that it was based on showed that the average length of stay for a heart attack was six weeks; two weeks for eye surgery.⁵⁹ Indeed, if you look at the history of teaching hospitals, patients were kept around precisely so the doctors could study their prognosis. You could stay for months in hospital, and once they discovered what was wrong with you, they would send you home because there was no treatment. So we never had a scientific approach to discharge. I used to have a line; I would say, 'If you read a medical textbook, when you get to "discharge" it only mentions pus.' It is still true.

There was no discussion in medical textbooks of what you do once you have diagnosed the patient and initiated treatment. It is always someone else's problem, somehow. So we had immensely long lengths of stay for no scientific reason. So, of course, there was this massive excess bed capacity – or you could say a mass of untreated people who should have been in those beds. So some bed rationalisation was probably inevitable, once somebody started looking in a tough way at things like day surgery.

⁵⁹ Probably a reference to the 1974 reorganisation, which was outlined in the August 1972 White Paper, *National Health Service Reorganisation: England* (Cmnd 5055).



James I would like to pick up on 1987, because by that stage I was negotiating with the Treasury; I had taken over from my old boss, Terri, at the end of the previous year. The 1987 crisis was also affected by the election of that year. Most authorities that were facing cuts put them off until after the election; the impact was twice what it would have been. We endeavoured to persuade the Treasury of the reality of this. Their attitude simply was, 'You have been getting by on this minimum amount of growth for the past few years; we do not believe you'. That was a very big misjudgement on their part, extenuated by having a new Secretary of State in John Moore who, frankly, was not up to the job.

Timmins Well, he made the mistake of believing that that his job was to give the Treasury what it wanted. He wanted to be a blue-eyed boy in terms of being tough on spending.

James He thought he could avoid the usual PES negotiations and just go to the Chancellor and say, 'May I have a deal; I used to work for you'; he did just this, and he was sent away with a flea in his ear.

Griffiths The Birmingham Children's Hospital has been mentioned. I was the district medical officer for this, so I know. What happened was two elderly cardiac surgeons retired, and they never operated on Downs' Syndrome children with heart disease because they did not think it was worth it. They were replaced by two young guys who were far better surgeons; they knew all this micro stuff and broadly it is still there, because it is genius. They put all the Downs' Syndrome children on the waiting list, so the waiting list

went up from about 150 to 300 and a crisis was born. At the beginning of the crisis, I think they were doing 160 operations a year, and the waiting list was about 150, and at the end of the crisis, they were doing twice as many operations and the waiting list was twice as big. But the crisis was declared to be over because the surgeons were doing as much work as they wanted to do. So not only do you have all these macro things going on, but there are a lot of little games going on underneath, and it is important to remember that. I did not tell anybody at the time because it seemed churlish.

Timmins

Can I just bring us back a bit, to the advisory group on resource allocation, which is only two years into this thing?

Gerrard

Do you think the advisory group on resource allocation had been superseded to a degree by the attitude adopted by ministers, from Patrick Jenkin onwards, who was saying, 'Let us give a lot more freedom to consultants, to health service administrators, they are the ones who work at the sharp end, they are the ones who run the service and I will be guided and encouraged by the information I get back from the administrators and from consultants'. That is somewhat base management rather than active policy.

Part Four –RAWP’s Legacy

Timmins That may be true, but can I focus on AGRA,⁶⁰ which was only two years into RAWP coming to life?

James I was one of several AGRA members here today. It was aborted – is the only word I can use – in the name of ministers, but I honestly think it was the officials concerned who believed that there would not be an appetite by the incoming government for further analysis here which might be used-for greater redistribution. The report was published on 1 January 1980, which is a good day to hide bad news. It failed to tackle most of the things it was asked to; those that it did were relatively unconvincing or straightforward, and on the whole, were probably favourable to teaching hospital interests. I and some others who were on that committee within the department were dissatisfied with this, and we thought, ‘Why do we not see if Walter could be persuaded to continue research on some of these issues’, so we went to see him; it was a routine review meeting to appraise the grant. We came out two hours later having agreed something completely different, but-which proved to be quite important, which was the study of avoidable mortality-between areas and reflecting social factors. Peter was there as part of that as well. So that was very, very unforeseen. However, I have no doubt at all that the ministerial team that came in in 1979 had not got many ideas of their own. The one they did-have was that they favoured the district tier over the area tier. Why? Because they had been traipsing up and down the country for the three years, and they met many more district administrators than area administrators. But beyond that, they were very uncomfortable; they felt that the department had its own agenda. This was *Yes Minister* time,⁶¹ and their attitude hit me firmly in the face about 15 months later, when I was asked if I would go to have a drink on the terrace of the House of Commons with Sir George Young. I got there and he said, ‘We would like you to write a paper for us– please do not tell anyone else - about what you might do to make the department more responsive’. I got back to my office, and my under-secretary wanted to know why I had been to see Sir George

⁶⁰ The Action Group on Resource Allocation.

⁶¹ A 1980s situation comedy set in a fictional Department of Administrative Affairs. Sir Humphrey Appleby, the Permanent Secretary, has become synonymous with civil service obfuscation and delaying tactics. See Shannon Granville, ‘Downing Street’s favourite soap opera: Evaluating the impact and influence of *Yes, Minister* and *Yes, Prime Minister*’, *Contemporary British History* 23 (3) (2009), 315-56.

at the House. I had that split second of, 'Do you tell the truth or not?'. I told the truth and the following morning, I was with Patrick Jenkin and the Permanent Secretary discussing what sort of staffing I needed for this new think tank I was going to head. Ministers did not, with certain limitations, have a big agenda when they came, in 1979.

One of the studies we did in this think tank was to identify how many pieces of policy initiation were going across the department: we found over 180, most of which were unknown to the minister responsible. So there was something in the concern, and I think it is wrong to believe that they came in with a clear agenda. They did not.

- Timmins** When you say AGRA was aborted, it was aborted by Jenkin?
- James** It was aborted in the name of government, but I am absolutely sure the advice from officials was absolutely clear.
- Fairey** It was something called the Pliatzky Review was it not?⁶² It was part of the Pliatzky cull, which was to get rid of the little working groups such as AGRA and we had to send in a return to the Treasury, 'Look, we have culled x'.
- James** The other thing you have is the Black Report.⁶³ I have to say I am actually partly involved; I came in at a very late stage but nonetheless I was one of those advising the ministers on what to do with this Report. The substance of the advice was, 'Here are 13 chapters of detailed, authoritative analysis by people who know they are talking about, and one chapter saying how by spending £14 billion' – i.e. about £250-300 billion now – 'you would resolve all of these'. We took the innocent view that the link between the solutions and the analysis would not convince anybody. So we created a best seller with the TUC's publication of the 14th chapter.
- Timmins** Absolutely. So we get AGRA abolished; we have ministers sticking with RAWP through the Fowler, Clarke era. There is this chart that shows there was some coming together at regional level, so at that level it sort of worked. But did it work over the longer run? Matt Sutton [Manchester]⁶⁴ produced a paper a while

⁶² A report conducted by ex-civil servant Sir Leo Pliatzky (1919-1999) as review of "quasi-autonomous non-governmental organisation", or quangos. Margaret Thatcher believed that many of these were a waste of resources, and that the least efficient or useful ones should be shut down.

⁶³ See note 30 above.

⁶⁴ Professor Matt Sutton has published extensively on health systems and inequality in the United Kingdom. Examples include Laura Vallejo-Torres, Stephen Morris, Roy Carr-Hill, Paul Dixon, Malcolm Law, Nigel Rice and

back that said, 'Basically what it did is it counted population growth and not much else, if you begin to look anywhere beneath the regional level', which comes back to this debate about what you do with areas and districts. It evened things up at a regional level, but at the level below that, it made much less difference.

Griffiths

It started off with five regions that were well off, and we ended up with five regions that were well off, and the rest. And we are still the most unequal country in Europe. So yes it did something, but it did not do enough.

West

May I mention one other policy that was going on at the same time, which was tackling some of the other inequalities? We have not mentioned this one, but I seem to recall that there was a clear policy over the last 30 years to put new medical schools in places that were resource-deprived and service-deprived. The argument was, among other things – for example, my brother has been in Leicester since his first week at medical school, he never left – medical training was so long that medical students would inevitably put down roots and so we had Leicester and Southampton to start with, and then subsequently, in more recent times, Plymouth, Hull and places like York and Exeter – rather more affluent. There was this policy of trying to address some other inequalities by creating bigger specialties, so more jobs outside London for the academically inclined and the specialist inclined doctor; and also encouraging growth in the numbers of doctors who might stay in these areas. That was another policy. Going onto the point about inequalities below regional level: the difficulty is that over the same period, there is more and more – and we are still seeing it today – thrust towards bigger critical mass in hospitals. There is a legitimate intellectual argument for having no hospitals in any meaningful sense in Cornwall; it is just a political nightmare. There is still a hospital in Penzance, I believe. I used to draw it on a map and the catchment area is 90% water, quite literally. But you cannot close it because it is the first and last hospital in Britain; it represents a stake in rurality. So inevitably these discrepancies at a district level were bound up with where the medical profession and other people were trying to go, in relation to the optimal size of hospital, which we are probably still struggling with now.

Matthew Sutton, 'Can regional resource shares be based only on prevalence data? An empirical investigation of the proportionality assumption', *Social Science and Medicine*, 69 (2009), 1634-42.

Timmins Of course there is also a broader economic growth argument about medical schools in places like Hull and Plymouth, bigger than the health service issue: driving the local economy.

Tudor Hart I just wanted to take up what Peter just said. If all specialist services disappeared from Cornwall, who would be looking after the people, who would be dealing with things, other than actually when they are inside a hospital? It would be the primary care system, which has hardly had a look-in today. Of course, it hardly had a look-in on RAWP, but it was always there, gradually evolving from just being a clutch, operating between the hospital services which were the engine; and the demand from sick people, which was always greater than could be coped with just by hospitals. We could not afford to be like Sweden, so we left these GPs, who liked to be left alone and therefore were left alone. Now, slowly if not in fits and starts, primary care has been becoming an increasingly effective branch of medicine that affects the outcomes of illness. Particularly for the care of chronic patients, who are surviving problems, they do not need to be kept in hospital for six weeks to see what happens. They are going to be there for 60 years, outside hospitals, and could be observed by scientifically trained people.
The need for RAWP in primary care is absolutely monstrous. I think it was the guy who wrote the American Constitution.

Timmins Jefferson?

Tudor Hart He said, 'There is nothing more unjust than to treat people who are unequal as if they were equal'.⁶⁵ I am not quite sure what he was getting at, because it could be something quite bad, but that is true. We have always been aiming at equal provision, equal investment per capita throughout the country so that will lead to equal outcomes. But of course it does not. The currency of medical care is time, not money. Of course you have to pay for the time, so you can translate it into money, but the patient currency is time. When the time was only two minutes per patient, in primary care, it could not support secondary care, specialist care as it should do. An enormous number of people were going untreated, particularly not followed up. They would go in and out, in and out of hospital being repaired over and over again because things were not being maintained. If we are going to get beyond that, in an area like most industrial areas, stretches of Tyneside, the

⁶⁵ The quotation, widely attributed to Thomas Jefferson (3rd President of the United States of America), is usually rendered as 'there is nothing more unequal than the equal treatment of unequal people'.

northeast, the south Wales valleys, we have absolutely got to address that.

When you discuss RAWP now, in the past, we ought to be thinking about the lessons for RAWP in the future, and apply it to primary care.

Timmins

The impact on primary care is something I definitely want to come to, in a bit more detail later on.

Glennister

Related to that last point, I think what RAWP did – which has not been reflected so far – was to get into the public domain and the professions more generally, the notion that you could allocate resources according to some rational criteria. It started with acute hospitals, but the formula exercise has now spread from that to mental health, to maternity and pharmaceuticals, then to primary care.

You now have a formula which, on AGRA, we had responsibility for not just hospital and community services, but for primary care too after a similar formula was invented. In a sense, you have the spread of formulae; I think there is over-sophistication. RAWP was probably right; it just got more and more complicated as time went on, whereas the great virtue of RAWP was that it was simple. Nevertheless, the other long-term consequence is that formularisation got accepted.

Hurst

That is absolutely right, and of course the other great innovation – and again, this may be getting ahead of your timetable – was to introduce allocations for unmet need; preventive allocations which have been in place for eight years now. They are fiddled about with, politically; and it has to be a political decision how much of the money should be spent that way, but some of it is spent on disability adjusted life expectancy.

Sheena Asthana

I am Professor of Health Policy at the University of Plymouth. I want to pick up on the point that you made about Matthew Sutton saying that, effectively, RAWP equalised shares across the regions, which is roughly what you would expect at a regional level, insofar as differences between regions are far smaller than differences at e.g. PCT level.⁶⁶ Then we moved on to this idea of how you apply it, and the fact that you did not apply it at a sub-regional level.

Since Matt Sutton did the area formula, something fairly similar to the outcomes if you had used RAWP has been applied at PCT

⁶⁶ Primary Care Trust. These were local administrative units responsible for primary care services in the NHS between 2000 and 2013.

level and is now being applied at the CCG⁶⁷ level. I think what is quite interesting is that, for me, the main legacy of RAWP is the way in which it has led to an understanding, a virtually unanimous understanding, and a meta-narrative, which sees need for healthcare being synonymous with deprivation or standardised mortality or whatever variable you would seek to use. I just want to pick up Rod Griffiths' point as well; we remain the most unequal country in Europe.

Just taking those three things together, are we not confusing the goals of healthcare equity, with health equity? As far as I am aware, healthcare has relatively little to do with health inequalities. I think the most generous estimates say that it may affect 12-15% of those. We are talking about education, income, parenting, lifestyle, and a lot of things which have nothing to do with the NHS. Conversely, if we look at what the NHS does well, is it not curative care and management of chronic disease? What we have done, since applying a RAWP-type understanding that deprivation is where curative care is required, is that we have focused funding, not at the areas that have the highest rates of illness, disability and morbidity and mortality – which happen to be the areas that are not hugely deprived, but are very old: Devon, Kent, Lincolnshire etc – but at deprived but young populations which have relative low levels of chronic disease and mortality – in unadjusted terms. So, if you look at crude rates of cancer morbidity, chronic heart disease, etc, they are a lot lower in areas such as Tower Hamlets and Central Manchester than in Cornwall and Cumbria. This makes me wonder if one legacy of RAWP is this slight confusion about the fact that standardised mortality is a legitimate indicator of healthcare need, if that makes sense.

Timmins

Yes.

Hurst

No, I do not understand that point. The first elements in the formula, surely, are age and sex? So, areas with elderly populations get more money; that is the very first thing that comes in.

Asthana

I have the figures; I can give you the figures. What happened with the area formula is it started off with age, and because you had an additive formula, as each of those additional need factors were put in, it effectively cancelled out the effect of age. In an area like

⁶⁷ Clinical Commissioning Group. These replaced PCTs in 2013 under the Andrew Lansley reforms (Secretary of State for Health, 2010-2012).

Dorset, its weighted capitation went up with the age index, and then it progressively went down to below actual population.

Hurst

Of course, they are very healthy people; people select themselves who can afford to retire to the south coast.

Asthana

Dorset has a cancer rate of 2.5%; Tower Hamlets has a cancer rate of 0.7%. You get similar differences, but less extreme, with coronary heart disease. So although Dorset has a healthy life expectancy, because Dorset is an elderly population, it has a high level of chronic disease and yet it gets a very low allocation. We have a situation, because of this meta narrative, where need is equivalent to deprivation; we have a situation where PCTs in 2010, such as Camden and Tower Hamlets, can pay £15,000 and £13,000 per cancer patient respectively, in their patch, and it is nothing to do with specialised hospitals. There were commissioners able to pay this much, compared to £4,000 in Dorset.

For somebody who believes in universal NHS, and I think that RAWP was about universalism, it seems to me that through technical issues, we have lost that. We are not providing equal access of care for equal need; we are institutionalising ageism. Sorry, I am getting a bit political, but I think there is something about this process, the meta narrative.

Timmins

I definitely want to come back in a minute. Can I take us back for a second? We have not talked about the 1986 review of RAWP which started to bring in measures like the Jarman Index of Deprivation and make the formula more complicated.

Banks

You have to look at the alternatives. If you are saying it is something good or bad, you must say what would have happened otherwise. If you fund revenue consequences, all the best-off hospitals had their plans ready. Or is it going to be a political process? As Graham said, every now and then with Norman Fowler and Ken Clarke, they absolutely kept it going, but one did have to say now and then, 'What is in this?'

Timmins

The logic for this, yes.

Banks

The NHS supported RAWP. I think particularly at national level – of course it does not work as well locally, and that is where you get the political interference. You must look at the alternatives. Coming to the RAWP review in 1986, I happened to be interviewed by the *Health Service Journal* at the time, so I know

what I said.⁶⁸ One of the points was that you do not keep on tinkering with it because you have instability. But every now and then, things build up to the point where you need to look, and it had been running 10 years.

Another point was that – and you can do an intersection on your graph – by 1986-87, all but two of the regions on the RAWP formula were within 4% of target. Therefore you needed to be roughly in the right ballpark, and you would never be any better than in the right ballpark, or it would stop making sense altogether. One key factor was terrific worry about inner-city deprivation. I remember going to the Whittington maternity services. I think it was either three or four neonates in intensive care, all of them children of refugee women who had been tortured and raped. That is where you get the opposite, of course, of the Dorset special pleading: ‘Just look what we are coping with in the cities’. So that was one major issue. The other issue was the increment for teaching, which was always a real problem.

West

To the point on what you could describe as the simplicity and elegance, in some ways, of the RAWP approach, I think it is important to remember that this does partly reflect computing power. You should never underestimate the ability of an analyst to expand the model to the size of his computer. I have recently been working on diabetes. NICE has now had to endorse a commercial model of diabetes because it simply cannot compete; it cannot do its own. So you are told to use this company’s model. It can take between two and five hours to run one simulation of a particular combination of drugs in diabetes on enough patients, to get a statistically reliable result. You may have to put two or three hundred simulations into NICE. So we have created an industry. The example I use is you are moving house and you are moving from a flat to a house with a garden and you decide that the cats will get more exercise but also be exposed to more infection, so there is a sub module in your spreadsheet where you work out the cost implications on cat food from exercise, and exposure to infections on vet bills, as part of your analysis, because you have decided you want a complete assessment. Now, everybody sensibly approaching the decision to move house, prioritises the mortgage and three or four other things. Really, whether the cat lives or dies as a result, you may be concerned, but you are not going to model it.

⁶⁸ See ‘Tough at the Centre’, *Health Service Journal*, 2nd October 1986 for Terri Banks’ interview with Stephen Halpern.

What we have given analysts is a capacity literally to simulate the health lives, the health careers of 10,000 people over a 40 year period, one-by-one. That is what these models do. It has become an industry in its own right that really ought to be restrained. RAWP avoided it partly because, perhaps, of the characteristics of the people there, but partly because, frankly, they did not have spreadsheets. They had not been invented. If they had to do it, they would have to do it laboriously with punch cards.

Timmins Yes. Going back, deprivation becomes a measure, because people got worried about deprivation and that produces different results. I am struggling here, slightly. It is coming back to the point that there was a beautiful simplicity to RAWP in the first place; we start putting in things like deprivation and other factors, which tend to offset the simple RAWP formula. You end up with a formula that does not make much difference in the end. Do you see what I mean? Terri, you said it was worth reviewing because the worst regions were within 4%, and then you bung in deprivation, and they go out again. So you are then trying to get them back closer again. I am not sure I am being clear, but the formula gets so complicated, does it in the end start making less difference?

Banks Certainly. As you get close to target, quite clearly, it is making much less difference.

Timmins Indeed, you then re-write it and the numbers all move?

Banks Well, do you want to or do you want to say, 'Hooray, we are as good as we can get it in an imperfect world, let us have some stability'. From time to time, you dip in and out, but you do not keep tinkering; that is the whole point.

Hart May I ask whether Terri remembers: was the Black Report and all that followed from that a factor in building deprivation in? People did get much more concerned about inequalities and their impact on health?

Banks Certainly, yes, they were very worried.

Hart I cannot remember now whether there was a political attack, if I can put it that way – perhaps not even political – but an attack on the formula on the grounds that it made no obeisance to the Black diagnosis and therefore needed to be looked at again. Of course, although you were right to say that after 10 years, it was a perfectly reasonable thing to do, to look at it again; on the other hand, politicians do from time to time say they are going to

review something as a substitute for doing anything at the moment.

Hurst

My recollection was that if the Black Report had an effect, it was in creating a strong climate of opinion, very widely, that things were wrong; that there were clearly health inequalities. But it took some time for that to affect the RAWP process; there was the Acheson Inquiry as well.⁶⁹ That was bringing it more in house and making it more respectable, if I remember rightly. I think it was after that, that the incoming Labour government of 1997 ordered that there be what I referred to 10 minutes ago, which was an innovation whereby there would be an allowance for inequalities in health, a preventive allowance, which there had never been. It goes back to the point that I made earlier, that it was equal access for equal care; it was not equal access for equal health. So that is now in there, although we could argue until the cows come home about whether it is yet appropriately in there, or done the right way.

If I could just go back to the review of RAWP, I think there is something that has not been mentioned yet, which may be a rather 'techy' point but terribly important; I think it is a bit more than 'techy' – it is a scientific point. Prior to the review of RAWP, the weighting attached to mortality, which was the only additional needs variable, was a guess, an assumption, and it was given huge weight.

Hence the implication in targets that money should pour towards the north of England and away from London. I think the review of RAWP was perhaps possibly – I do not know about this – set up in the hope that that could be moderated. More importantly, the 'techy' point: the idea had emerged that it should be evidence-based; that we should not just guess things but we should have some reason for allocating money in accordance with mortality or deprivation. I think perhaps Scotland had pioneered that; I cannot remember. But it led to a commission from Coopers and Lybrand and small area analysis has been a part of revisions of the RAWP ever since.⁷⁰ In other words, it has to be evidence-based. We have to do a hell of a lot of very sophisticated regression analysis to cut

⁶⁹ Sir Donald Acheson (1926-2010) had been Chief Medical Officer from 1983 to 1991. He chaired an enquiry into public health (1986-88) while Norman Fowler was health secretary (published as Cm 289). He is also remembered for his report on inequalities in health, commissioned at the behest of the incoming Blair government. *Independent Inquiry into Inequalities in Health: Report* (London, 1998).

⁷⁰ Coopers and Lybrand was a consultancy and accountancy firm. It merged with Price Waterhouse in 1998 and is now known as PricewaterhouseCoopers.

the ice with the academic world. It would not be respectable not to do small area analysis now.



Glennester In a sense it became necessary after the reforms of 1989, to be able to get allocations down to the area or district agencies who were going to be the purchasers. Work had been done which enabled – I think it came from the Department of Health – census based local small area variables being introduced in the 1991 census, like long-term illness.

Hurst That came along a bit later.

Glennester But these variables could be used on a census basis. So it was not only the capacity to do this area-based stuff, but there was also information available which was based on the census, which could be done on a small area basis. So you have both the computer capacity and the data capacity, and you have the inferred need, allocated down to a district. All of these things came together to create a new requirement and the capacity to do it.

Hurst Small area analysis using mortality data at postcode level was conducted for the Review of RAWP. The review of RAWP is 1988, prior to *Working for Patients*,⁷¹ so this was still the old structure.

⁷¹ *Working for Patients* (Cm 555) was the 1989 White Paper outlining the future of the NHS, and is associated with the introduction of the internal market.

You are absolutely right, that actually there was a complete feedback circle in that those of us in the department who were trying to think how to improve the formula, following the review of RAWP, realised that if we were able to include questions on limiting long-standing illness in the census it could be used to improve small area analysis. In a sense, that had been foreshadowed in the first RAWP report, in the maps that were published. I think limiting long-standing illness was a question already in the General Household Survey. I remember communicating with Terri's organisation; Terri, you were Registrar General by then?

Banks

Yes, I was by then.

Hurst

Well, we asked your department to put limiting long-standing illness in the census, because then we would be able to do small area analysis with limiting long-standing illness.

Banks

I think we put in 'a long-standing disability that limits your activities'. That was the definition.

Hurst

So this was full-circle. This was RAWP, or the successors to RAWP, actually trying to change the census data so you could improve the formula.

Griffiths

One of the things we have not talked about is the balance between supply-side pressures and the providers and purchasers. We have messed the purchasers around by reorganising every three or four years into different units, as often as possible almost, which is quite disempowering. But at the same time, we started off with capital schemes and RCCS which was a supply-driven health service, but then we moved towards a population-based allocation and RAWP signalled that, and I think that was quite important strategically. But then we had Foundation Trusts; we have made the supply-side much more independent, and although it does not create aggravation directly in the formula, it creates political pressure to mess the formula about, or to cause some other way of being able to deal with who is going bankrupt and who is not.

I think that has messed things up over the last decade a bit, much more than it needed to have done. In theory, we should have had GPs integrated into the system, and one whole health service and we have thrown it away. We are now allocating resources to CCGs, but we have made them so small that they have not much chance of actually doing a job. At the same time, we have tried to

make all the trusts independent so they can run amok. We are not very good at this in the long-run.

West

‘You could not make it up’, is the phrase.

Tudor Hart

The NHS has always been a redistributor of wealth in society, and that is the reason that it is always fiercely contested and will never become apolitical. This idea that the age standardised mortality rates might be a less-good proxy for need than age has come up in the literature recently, and it is soon, I think, going to spread to the *Daily Mail* and things like that. Then it will become really serious.

I am 86; I am damned lucky to be 86. I make quite heavy demands on the health service but if all the people like me are going to get a lot more money spent on them, all these fortunate people who are, on the whole, richer – that is the reason they live longer – you are actually proposing a reversal of the old RAWP formula, which was at least trying to do something about inequalities in service, compared with need. I really plead for us to remember what was said this morning, that SMRs were chosen in the first place because they worked, they were a valid proxy for need, and above all, they are readily understandable not only by doctors and statisticians, but also by ordinary people, by voters. With a bit of explanation, they can understand about deaths and doctors can even tell the difference between somebody who is dead and somebody who is alive, which is more than they can do with an awful lot of the disease specific rates for mortality. So please hang on to it.



Colin Sanderson Professor of Operational Research in Healthcare, London School of Hygiene and Tropical Medicine. Just endorsing the point in academic circles of why, with this weighting of '1', if you get 10% more SMR, you get 10% more money. It was a very clear judgement, and that was the good thing about it. What happened was, they said, 'Come and do this on an evidence-base', and then we have regression. There is another judgement which says that, roughly, the average utilisation, given this, that and the other, is right. The idea is to give money on the basis that everybody should get the average. Some people underuse; some groups persistently underuse. That does not take into account any of this stuff. What you are trying to do is base what is an 'ought' judgement on a series of observations on data. There is always a judgement hidden in there somewhere. I think the good thing about the SMR is that it is very clear that it was a judgement. The risk with an increasingly complicated formula is those judgements get buried, and then people say 'subjective'.

Timmins Just to go back to the primary care point, we now have weighted capitation knocking around for primary care. At the time RAWP was first done, was there any consideration given to try to do it for primary care or was there simply not enough data?

West To some extent, primary care was already formula driven because of the capitation formula. Now you could argue that it did not take enough account of the problems between areas, or you could argue that, actually, everyone sees their GP a bit, and the amount of GP time spent on very, very seriously ill people is not hugely more. It is more than people who are not very sick but it is not massively more, so you could argue that there was a framework. I can also remember, a bit later, there was this wonderful concept called 'ASTRO-PU's'. ASTRO-PU's were a standardised prescribing unit score. ASTRO-PU's were a way of working out how much the drugs budget should be, because you could argue that the GP's time is not so excessively spent by the very sick, but of course the drugs budget is. So that was a further contribution in primary care, to standardising the methods used to work out the prescribed drug element. One other point about RAWP itself: we did some calculations involving age-specific standardised mortality ratios – that is to say, looking at the mortality ratio by age group. All the populations cancelled out. So what it boiled down to was that you had twice as many deaths; the formula did not care whether you

had twice as many people or the same number of people who were twice as ill. It just came down to absolute numbers of deaths if you did an aged standardised model. Now that would have been a hard sell. SMR sounds more scientific; the reality is that, actually, it just came down to the number of deaths if you did it more detail.

- Woods** Going back to your question, the terms of reference excluded family practitioner services. The committee recognised that this was a problem and that it needed to be addressed, and pages 80-81 of the report talk about the reasons why it is important and suggest further study.
- Timmins** Was this a great policy success? Does anybody think it was not?
- Hart** I don't think it could have gone faster; Rod has made some suggestions that in the late-1970s and 1980s it did not go fast enough. I say it could not have gone any faster and in fact, probably, some of the time went too fast.
- West** Just to pick up on that point, in 2000 I met a public health official and doctor in Barnsley who wanted all of the money transferred the next day: no ceilings, no floors. I said, 'You cannot spend it on hospitals'. She said, 'No, I want an industrial scale investment in public health programmes. If you give me all this money from Leeds and Harrogate, I can be fixing the health of Barnsley in the community as soon as you give me the money'. It actually turned out to be quite difficult to define what she was going to do. There was certainly a case for saying somebody could have been much bolder about it, but the politics of that are really difficult. Once you say, 'We are not going to have a floor', well, a third of the hospitals in south London or Bromley are going to shut. Bromley happens to have a lot of hospitals because it was on the train lines to the First World War. The politics of that would have been very difficult I think.
- Woods** It takes a while to build a hospital too.
- Griffiths** If you have not spent money in the past, people do not know how to do it. I would have had that view: 'Give us the money and let us get on with it'. But up until Blair actually came along and started giving money, there was a whole generation of managers who had no idea what to do with the stuff. A lot of the mess we are in now could have been avoided if we had invested in being able to cope in the longer term. Far be it from me to agree with Graham, but I think there is a pace issue that you have to get

right. That is quite a piece of maths. It also requires a learning organisation, which you do not get if you reorganise something every five minutes and fire everyone who knows anything.

- Timmins** Is there anything we have not covered, if someone in here has a burning desire?
- Gorsky** I was wondering whether there was anything to say about the Royal Commission of 1979 which had a paper, but I suspect because people have not picked it up, it probably does not matter all that much.⁷²
- Rivett** A great policy success. I talk from time to time to medical students in the United States and I usually produce the spending in their state. Mississippi: half the spending of Minneapolis and Massachusetts. Goodness, 'Obamacare' has a problem if it ever gets going.
- Hart** I have only one regret, that I was never able to stamp out the use of the phrase 'postcode lottery'. It is now absolutely deeply entrenched in our political world, and it is nonsense.
- Gerrard** I have spent a certain amount of time looking at the health system in America and one of the things I have noticed there is that public health, the public hospitals, the public provision of prescriptions and medical treatment is not in any way as good as it is here. When I was the director of ACHEW I went over to Washington and Connecticut.⁷³ In Connecticut, I met a very large unit they had as part of the state government which was dealing with disability and rehabilitation and all the things to do with providing for people who had special needs. The truth was they envied us, the purity of our service, which was aimed at the people and not at the machinery for making things go. That was the view they took: that we had many, many cultural and other outside influences on our health service that was superior to the public health service in their country. I would endorse that.
- Asthana** I think RAWP was a great success was bringing about a decline in regional variation. I think there are legacies in terms of our understanding. I would argue that this includes the medicalisation of health inequalities, whereby we have increasingly come to see health inequalities as something that can be addressed through the NHS. That links, somehow, into this concern about standardised mortality rates which are very closely

⁷² Sir Alec Merrison chaired the *Royal Commission on the National Health Service*, which published its findings in July 1979. Cmnd 7615.

⁷³ ACHEW – Association of Community Health Councils for England and Wales.

associated with poverty and deprivation. By the way, I am not a Tory, I am not a *Daily Mail* person; I happen to believe in the universal NHS. I would argue that proposing to use SMRs threatens that principle of universalism.

I also do not understand how you can say that older people have had a certain amount of life (a fair innings) and thus don't deserve healthcare anymore. Yes, some older people may not care so much about receiving health care. But some do and I find it hard to morally justify depriving them on the basis of age alone.

West There is an argument, Alan Williams' fair innings argument, I find quite plausible, as I get older.

[Crosstalk]

Astana But most people do not get ill until they are 70! If you restrict access to the NHS after that age, what is the point in having an NHS at all?! It is the stupidest argument I have ever heard. Some people get ill prematurely; great, give them NHS care. Some people do not get ill until they are 70. Why do they not deserve it?

[Crosstalk]

David Lawrence We have not got time now, but I would appreciate a much more in-depth discussion on this point, because it is current now with what is happening in the NHS, and therefore needs further discussion.

Timmins May I say thank you very much to all of you for coming. I hope you have enjoyed it, and there is a glass of wine outside, I believe, so we can carry on debating all this as we go.

Gorsky A quick word before we move on: thank you to everyone for coming and contributing, to remind you that those of you who have spoken, we ask you to please sign and give us a consent form which allows us to record you. We will transcribe what has been said this afternoon and get that transcription to you so you can check, amend, add footnotes etc, to your contributions. It will be in the hands of the transcribers, and it may take us to the New Year to do that. Let me just wrap up by inviting people to have a glass of wine on the way out.

Appendix

The following texts were received after the Witness Seminar from David Pole, a retired civil servant who was the Senior Economic Adviser in charge of the Health and Social Services side of the Economic Adviser's Office at the Department of Health and Social Security at the time of RAWP. The first section is extracted from an account written about twenty-five years ago, which has been edited only to suppress a few names. It was part of a more extensive memoir, not intended for publication. This is followed by an additional commentary on these events, written in 2014. The footnotes have been added by Martin Gorsky, with David Pole's agreement.

Part 1

The role of the Economic Adviser's Office in RAWP

by David Pole

What really put the Economic Advisers' Office (EAO) on the map, so far as the Department (DHSS) generally was concerned, was the arrival of the Labour government of 1974, and of David Owen as Parliamentary Secretary and later Minister of State for Health. I first came across Owen at an introductory meeting between Leonard Nicholson, the Chief Economic Adviser, and Barbara Castle, but it may have been Brian Abel-Smith, who had been my contemporary at university, and was now a Special Adviser to Barbara Castle, who brought us to his notice.

Before Owen had been long at the Elephant, I was summoned to a meeting in his office, at which he asked the capital planners why he was being expected to endorse the construction of a new hospital in Boston, rather than any of the other towns that would have liked one.⁷⁴ The best answer they could offer was that Boston had been promised a hospital in the thirties, and was getting impatient, and that some millions, which had already be spent on various preliminaries, would be wasted if the project did not go ahead.

Dr Owen was evidently not much impressed by that, and at the end of the meeting he asked me and George Kerr, the Under Secretary responsible for capital planning, to stay behind. He commissioned the pair of us to produce, within three weeks, a list of between five and thirty criteria which would guide him in future to a more rational choice among possible locations for new hospitals. Kerr was large man, kindly but formidable. He had been Poulson's business manager, on secondment from the department, but had survived Poulson's downfall.⁷⁵ Ron Matthews once remarked to me, perhaps by way of an apology for the Poulson episode, that 'if you pointed him in the right direction, George would go through a brick wall'. When we got outside Owen's office, Kerr looked at me benignly, and suggested I should go away for a year or eighteen months, by which time, he must have calculated, Owen would have moved on, and do a proper piece of economic research on the subject. Meanwhile, he and his colleagues would do the best they could with the crude methods at their disposal.

I naively assumed that, in this way, Kerr had given EAO a licence to pursue our own line of enquiry. Jeremy Hurst and I went to meet the branch in Kerr's division that was responsible for capital allocations, and a Principal gave us a vivid account of the imponderable elements that might affect the need for hospital services in any particular area, which he explained were such as to make rational planning impossible. When I asked him how decisions were actually made in face of so much ignorance, he could offer no answer, beyond flippantly remarking that one found out where the local M P and the chairman of the hospital board lived, and took it from there.

⁷⁴ The DHSS was located in the Elephant and Castle district of London.

⁷⁵ John Poulson was an architect and businessman who was notorious in the early 1970s for a financial scandal involving bribes to public figures for the reward of contracts. The Conservative Home Secretary Reginald Maudling was implicated in the scandal and forced to resign in 1972, and Poulson himself was imprisoned in 1974.

I knew we could do better than that. A few days later, without further reference to Kerr's division, I put up to Collier, the Deputy Secretary, a longish paper, in which I attempted to conceptualise in economic terms the problem of allocating capital in the NHS, and suggested twenty criteria to be used for the purpose. Various other divisions also contributed papers, and Collier, sending them up to Owen, apologised for the quantity of material, but suggested that it might not be necessary for Owen to read the EAO paper. Owen did, of course, read it. He immediately set up the Resource Allocation Working Party (RAWP), and capital allocations were subsumed with revenue allocations in its remit.

While he was working at the Oxford Regional Hospital Board, John Rickard had done an analysis of the distribution of revenue expenditure among the areas in the Oxford Region. When he joined the Department, I asked him to extend his analysis to the hospital service as a whole. The disparities Rickard's study revealed were very large. It turned out that Sheffield was the worst off region, and Leicester the worst off area, not only in the Sheffield region but also overall. In fact, Liverpool got nearly four times as much, per head of population, for its general hospital services, as Leicester did.

Differences in the availability of health care facilities largely resulted from charitable endowments, dating from long before the inception of the NHS. These had been only slightly mitigated by local authority investment in hospitals. The differences had persisted because revenue allocations were increased annually by a general percentage increment. Such changes in the distribution of recurrent resources as had occurred since 1948 were largely related to the building of new hospitals, such as the one at Boston, or the rebuilding of old ones. New building attracted additional finance (known as RCCS - the revenue consequences of capital schemes, a concept unknown to economics) to sustain the allegedly higher cost of running new facilities.

Paradoxically, a large part of new building occurred in the better-provided areas, because any suggestion for rationalising facilities, often old and out-of-date, in over-endowed areas such as Liverpool, invariably resulted in proposals from the region for a radical programme of rebuilding. In fact, Liverpool had recently had a huge and disastrously expensive new hospital, in spite of the fact that it already had far more beds than it needed. As a consequence, such rationalisation as occurred was more likely to increase the inequality of revenue provision than diminish it.

So far as I know, the size of these local disparities was not well recognised either by the doctors, administrators and statisticians in the Department, or by the doctors, administrators and populations of the areas concerned. It is hard to believe that such inequalities could have been allowed to persist if they had been recognised, but the scepticism that prevailed in the relevant parts of the Department about the possibility of a more rational approach meant that nobody, before John Rickard, had had much interest in establishing the facts. Nobody had been moved to do anything about the disparities, before the arrival of Dr Owen. Moreover, they seemed to give rise to little local pressure. People in Leicester, including my numerous relations, were just as proud of their hospitals as people were anywhere else. If the Leicester consultants had any inkling of the situation, they had good private reasons for keeping quiet.

A distribution of finance based simply on the size of the population would have been much fairer than the existing distribution, but it would have been impossible to get it past the sceptics in the Department. The need for health care did clearly vary between different parts of the country. There were large observable variations in morbidity, but morbidity statistics were sparse and unreliable. Variations in reported rates of illness were partly caused by the very variations in the availability of services that we were hoping to eliminate.

Mortality seemed to be regarded by epidemiologists as the best available proxy for morbidity, but aggregate mortality statistics would have given a distorted measure of financial requirements, because mortality rates and cost per case differ greatly among different types of diseases. Places with a high incidence of deadly diseases, which involved little cost to the service, would get more than their due. Pondering the problem in the early hours, it occurred to me that the best approach would be to disaggregate mortality data and relate it to costs. Data were available which would enable us to estimate an average cost per case for disaggregated groups of diseases or specialties, and in that way to construct an objective measure of the relative total requirements for each area.

At the next meeting of RAWP, I boldly proposed an allocation formula based on disaggregated mortality data. The implicit assumption was that the case-fatality rate was reasonably constant between areas. Walter Holland, the professor of epidemiology at St Thomas's, who was one of the medical experts on the RAWP group, fortunately supported me. Morbidity also varies a lot with age, so the age composition of the local population would have to be incorporated. For some diseases, such as mental illness, sex is also a significant variable. The group adopted this approach, without much dissent, and devised a formula by which it proved possible to generate a set of indices of need, based on these variables, which were sufficiently robust to command acceptance.

Jeremy Hurst did a lot of detailed work on costing, and several other members of EAO, including John Rickard, were involved. An Under Secretary called John Smith was put in charge, the committee's report was published and the new system was quickly adopted. With minor modifications, it has continued in use ever since.

The people responsible for operating the existing system were conspicuous by their absence. It appeared I had offended them deeply. Kerr soon returned to his native Newcastle, voluntarily accepting demotion to Assistant Secretary, and took charge of the vast benefit office headquarters there. Although I remained on friendly terms with his former Assistant Secretary, with whom I had worked in his previous job, I realised much later that he never really forgave me for invading his territory. He once introduced us at lunch to a new female member of staff by saying "I'm [So-and-so]. I do [such and such]. This is David Pole. He does everything." At the time, I thought he was just being silly. After all, I had only done what the Minister had specifically asked me to do and, although EAO served the whole Department, we only gave economic advice, and only when asked. Apart from the invasion itself, the formula-based system, which we had proposed, removed practically all the discretion that he and his colleagues had previously had in the matter of capital allocations.

There was a shocked reaction from the areas in the NHS that had prospered under the existing arrangements. No region was allowed actually to lose revenue, and the new system was phased in to avoid disruption of services, but some regions got practically no increase in revenue for several years, until a measured equality was eventually reached. When I moved to the Treasury later, the assistant secretary there who dealt with NHS matters told me, not knowing how much I had been involved in setting up the scheme, that the Treasury had managed to slow its introduction right down, because such initiatives always cost the Treasury money. I was not amused.

After RAWP, David Owen made a habit of asking any Under Secretary who submitted a paper to him whether the economists had seen it, and what they thought about it. For a time, I had the unfamiliar experience of having powerful senior administrators hanging on my word. Early one morning, I saw a Deputy Secretary's jaw literally drop as I entered the room, my invitation to the meeting, the previous evening, having been left rather later than convention would have required. Owen gave me direct access to him and, if I had been more enterprising, and more experienced in the service, I could have done more with the opportunity his patronage provided us with, though probably at even greater cost to my popularity.

The RAWP experience was a fairly convincing demonstration to the top of the Department that the microeconomic approach, sustained by political will, could benefit the efficiency of the public services. As George Kerr had anticipated, Dr Owen did not last long, before going off to the Foreign Office, but the leverage we had acquired persisted throughout my time in the service and, I think, still persists, though the two halves of DHSS have become separate departments.

Part 2

David Pole now adds:

At the time, Jeremy Hurst and I were just conscious of being in a battle, but the things that now strike me about the early stages, when I was most involved, are the adventitiousness and the contingency of key events in the development of the RAWP process. Those may be characteristics that interest historians.

For instance, Dr Owen's initial interest was fairly remote from the main problem RAWP was asked to tackle, which was the equitable geographical distribution of current finance; and I think his motivation was mainly political. As an incoming Minister, he was being asked to sign off a project initiated by the outgoing government, a new hospital in a Tory area. He would obviously have much preferred to be authorising a hospital in a Labour area, of which there may well have been some that were more deserving. In fact, I recall that he suggested at the meeting, as a hypothetical alternative to Boston, a town in the Labour Lancashire heartland, probably Barbara Castle's constituency of Blackburn, or perhaps Preston.

I never knew how Dr Owen's problem of deciding on the location of new hospitals mutated into the wider one that RAWP was set up to tackle, but the change followed immediately after he received the papers from the Deputy Secretary. I guess it was Brian Abel-Smith who advised Dr Owen, on the basis of EAO's response to his original problem, to broaden the study by setting up RAWP. By that time, Abel-Smith was probably as much of a social administrator as an economist, but he could recognise an economic argument when he saw one. He may also have been more aware than I was of others' having raised the problem of the unequal distribution of current finance. I had been a contemporary of Abel-Smith's at university and when he discovered, more than twenty years later, that I was working at DHSS, our previous acquaintance probably had a bearing on the prominent role EAO was then given.

I think George Kerr seriously hoped and even expected that, as an academic and a neophyte civil servant, I would fall for his proposition that we should do a 12-18 month research project, and I admit I said nothing to disabuse him. He was a heavyweight, literally and figuratively, and outranked me, and was not lightly to be contradicted. I felt also that it was he, not I, who was proposing to breach the terms of the Minister's remit, and would bear the responsibility for the consequences, which I had no difficulty in foreseeing, of our going our separate ways; though that turned out to be no defence for us against the displeasure of his administrative colleagues.

It was a time when microeconomics was expanding into new fields, and DHSS, on the health side, was virgin territory. When I joined the service, I decided that our job as economic advisers was to give economic advice to Ministers and officers as and when they needed it, not to do research. For the first two or three years, there were only Jeremy Hurst and me, and we were already engaged with Finance Division in developing a programme budget for the Department, in accordance with government policy and the fashion of the time, as well

as our advisory work. Nevertheless, I was once censured by no less a personage than Alan Walters for EAO's not having produced any research in health economics.⁷⁶ (He slightly undermined his authority on the subject by confusing Martin Feldstein with Marty Feldman.)⁷⁷

I do not know how far we should have got if we had been required to agree everything with Kerr's division before submitting it. They were not receptive to change. In fact, they took no part at all in RAWP that I can remember. After twenty-five years of administering the finances of the NHS, they were convinced that the job was so complex that it was only through their experience and the exercise of their discretion that it could be done. I do not think they foresaw any possibility that a more systematic way of doing it would be found. I never saw the paper Kerr's division put up to Owen, so I cannot say what proposals it may have contained, but I doubt whether they would have resulted in any significant change in the way the division did its business.

We were fortunate in our chairman. For John Smith, RAWP was his last job before retiring, so he was under no career pressure to placate his administrative colleagues, and he ran the committee in an admirably positive and open-minded way.

I had got actively involved in health economics in the first place because Archie Cochrane was a professor of medicine at Cardiff, and knew my boss, the professor of economics.⁷⁸ A group that Cochrane was involved with at the Nuffield Provincial Hospitals Trust thought it needed the help of an economist, and I was the obvious person in the Cardiff economics department to provide it.⁷⁹ I had thus already, before I joined the Government Economic Service, got to know many of the epidemiological top brass, and had had an unusual amount of exposure for an economist to progressive thinking in social medicine. My association with those now legendary figures, as well as the bits of work I had done for NPHT, may have given me some credibility when I came to express EAO's view at RAWP.

⁷⁶ The economist Alan Walters (1926-2009) was Chief Economic Adviser to Margaret Thatcher between 1981 and 1983 and was associated particularly with the monetarist policies pursued in this period.

⁷⁷ Martin 'Marty' Feldstein (b.1939) is a Harvard economist who served as economic adviser to the Reagan administration; he has published widely in health economics, including early work on hospital costings based on study of the NHS, see *Economic Analysis for Health Service Efficiency: Econometric Analysis of the British National Health Service*, Amsterdam: North Holland, 1967. Martin 'Marty' Feldman (1934-82) was a British comedian who appeared regularly on television in the 1960s and 1970s, and was celebrated for his zany humour and striking appearance.

⁷⁸ One of the leading figures in mid-twentieth century social medicine, Archie Cochrane (1909-88) was Director of the Medical Research Council Epidemiology Research Unit, Cardiff, Wales (1960-74). His book *Effectiveness and Efficiency - Random Reflections on Health Services* (1972) is one of the founding texts of health services research; it called for medical procedures and technologies to be properly evaluated by randomised controlled trials to establish their real effectiveness. The Cochrane Collaboration (founded 1992) which archives and synthesizes such evaluations is one of his major legacies.

⁷⁹ The Nuffield Provincial Hospitals Trust (NPHT) was established in 1940 by Viscount Nuffield (William Morris), the founder of Morris Motors. Before the NHS its main focus was advocacy of greater regional integration of voluntary hospitals, and the surveys of hospital services which it produced with the Ministry of Health, 1942-4, influenced discussions of regionalisation in the NHS. By the 1960s it had become a major funder of health services research, sponsoring projects examining maternal and infant health, dental health, service utilisation, casualty care, hospital design and planning, mental health, and postgraduate education as well as supporting operational research units.

The epidemiologists I had worked with at NPHT all naturally held provincial chairs. I was unfamiliar with the metropolitan milieu from which Walter Holland came, but it evidently included David Owen and Brian Abel-Smith. Holland was as committed as they were to finding a solution and his endorsement of the EAO proposal to use cost-weighted mortality data, as a measure of relative need, was decisive. After that, RAWP accepted that a rational solution to the problem of distributing finance to the regions and areas was possible, and immediately went into administrative mode. EAO's role devolved on Jeremy Hurst, who carried it out with his customary thoroughness and tact.

There were dissenters. Some people were inclined to dispute the principle of trying to equalise the geographical distribution of financial provision. One of the Deputy Chief Medical Officers told me it was a mistake to take money from centres where it was being used efficiently – I suppose, thinking mainly of London hospitals – and give it to peripheral places where it would be used less efficiently, in medical terms. That is a very doctor-centred point of view, but it was probably quite prevalent in medical circles at the time.

I have not followed the subsequent development of the RAWP formula, and I am not concerned now to defend the particular solution we proposed. All I would say is that, whereas before EAO made the proposal, there was room for widespread scepticism about the possibility of finding a rational solution, it was clear to everybody afterwards that there would be no going back.

RAWP had progeny, of dubious legitimacy. In 1976, I was transferred to H M Treasury as head of the Public Services Economic Division (PSE1). Devolution was in the air, and Alastair Balls, the economist who had been given the task of working out the financial implications, sought me out. RAWP appeared to be the only extant paradigm, and we discussed the possibility of using a similar approach to other potentially devolved public services.

In the event, the devolution referenda were lost, but Balls then transferred his attention to local government finance. The outcome was the Standard Spending Assessments (SSA) for local authorities. The previous arrangements for distributing Exchequer finance were insanely inefficient, but the local authorities defended them desperately, and with cause. As part of its policy of rolling back the state, the Thatcher government converted SSAs into a means of capping local authority expenditure. In the end, RAWP may have done more harm than good to the body politic.

RAWP made a lot of work for the statisticians, which some of them resented. When I went back to the Department in 1980 as Chief Economic Adviser, Alex Macdonald, the head of OR, gave me a copy of a paper that was circulating at a high level in the Department, but had not been copied to EAO. It had been written by one of the Departmental statisticians, who complained about EAO's 'buccaneering' approach to data, which had inflicted a heavy burden on them. Thanks to Alex, I was able to set the record straight, but it was evident that, whatever the truth may have been about EAO's part in RAWP, some of the statisticians were still blaming us for it five years later. All in all, we managed to upset quite a range of people.

August 2014