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FROM THE PRIVATE SECRETARY
TO THE SECRETARY OF STATE
FOR WALES

14 October 1988

Dear Private Secretary

NHS REVIEW: MANAGEMENT OF CAPITAL ASSETS AND INVESTMENT

The attached annex ~~should~~ WITH PG. have been sent with my Secretary of State's minute to the Prime Minister of yesterday's date. I am sorry about the omission.

I am copying this to the Private Secretaries to the Chancellor of the Exchequer, the Secretary of State for Health, the Secretaries of State for Scotland and for Northern Ireland, the Chief Secretary, the Minister of State at the Department of Health and to Sir Roy Griffiths, Professor Griffiths and Mr Whitehead in the No 10 policy Unit, and Mr Wilson in the Cabinet Office.

Yours sincerely

F J Clements

Miss F J Clements

Private Secretary
10 Downing Street

ANNEX A

HOSPITAL WAITING LISTS IN WALES

Estimated cost of reducing waiting times to guidelines by tendering for key treatments

1 Guideline times The Welsh Office has issued guidelines to the NHS in Wales which set down the maximum times that patients should have to wait for treatment. These are:

Urgent in-patient treatment	1 month
Non-urgent in-patient treatment	1 year
First out-patient appointment	3 years

2. Number of patients waiting longer than guideline times One-third of patients have to wait longer than the guideline times for treatment; in particular over 60 per cent of urgent in-patient cases are having to wait for longer than 1 month. This despite a continuing increase in throughput of in-patients, day cases and out-patients. There are two contributing factors. First, demographic and technological pressures lead to more patients wanting more treatments; second there is an inherited backlog of cases.

At 31 March 1988 the numbers of patients in Wales waiting longer than guideline times was as follows:

Urgent in-patient cases	1,856
Non-urgent in-patient cases	9,358
Out-patients	30,286.

3. More than three-quarters of the inpatients and nearly two-thirds of the out-patients are from one of just five specialties:-

General Surgery (which includes repair of hernias and varicose veins)

ENT

Trauma and Orthopaedics (which includes hip and knee replacement)

Opthalmology (which includes cataract operations)

Gynaecology

4. BUPA quote £2,800 for a hip replacement operation (for which the prothesis costs over £1,000), and £2,600 for a knee replacement; these are relatively expensive operations to carry out. Varicose vein treatment or a tonsilectomy would cost about £500. There is no reason to believe that the NHS could do operations of this type any cheaper. In any event, this issue would be settled by a process of competitive tendering.

5. Cost of clearing the backlog A very rough estimate of the total cost can be made assuming that all cases cost the average price within the NHS (in-patient cases £745, out-patient cases £72). However, this will be inaccurate on at least two counts. First, the cross section of cases on the waiting lists is unlikely to be typical of the work of the NHS; second, the effect of increasing throughput may change unit costs in a perverse way, particularly if staff have to be paid overtime rates, and additional but inefficient facilities are brought into play. This would have the effect of making private sector bids more competitive.

6. With these caveats in mind, we have estimated the cost of clearing the backlog of patients waiting beyond target time for treatment. At 1988-89 prices it would cost £8.4 million (for in-patients) and £2.2 million (for out-patients) - a total of £10.6 million.

7. Need for recurrent investment A single injection of cash would do much to remove the present problem of excessive waiting times; but an element of the additional expenditure would need to be made recurrent to keep the times to our targets.

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PRIME MINISTER

NHS REVIEW: MANAGEMENT OF CAPITAL ASSETS AND INVESTMENT

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I support the proposals which Kenneth Clarke makes in his paper HC45 on the management of capital assets and investment in the NHS.

We have already achieved substantial devolution of responsibility for the management of capital programmes to our district health authorities in Wales and used brokerage and virement extensively to facilitate large capital expenditures within devolved programmes.

I support the introduction of real charging for the use of capital assets. We shall need to give careful consideration to how we are to determine appropriate depreciation on interest charges, against a background of widely differing age profiles of existing capital stock, and where the life of new assets will vary from one to 60 years or more. The regime we come up with will need to reflect the range of variation in the quality of capital stocks between authorities.

We must recognise in our proposals the need to strengthen dramatically the finance function in health authorities. I see this as a fundamental weakness of the NHS and proper funding of health care will require sustained investment in people and systems.

Increasing access to private capital, without jeopardising the principles Kenneth sets out in paragraph 6 of his paper, will be crucial to demonstrating to the public that our review of the NHS has led to improtant outcomes that will improve patient care. It is vital that we build in positive incentives for health authorities to make a good return on investments from income

generation and other schemes and that we do not make compensating reductions in public allocations.

We have already in Wales blazed a trail by contracting out some of our subsidiary renal units. The private sector operator is doing each session of dialysis for £60-£80 compared with the £100-£120 price quoted by the health authorities who tendered for the work.

I would like to extend this approach to other areas of health care where the private sector can offer good value for money. We would gain massive advantage from a major initiative, launched as part of the conclusions of the review, to reduce waiting times to agreed targets by a concerted programme of tendering in key areas. The annex to this minute shows what would be needed to reduce the waiting times to target in Wales. The expenditure is modest: under £11 million initially, an element of which would need to be recurrent. Such highly visible action on this most politically sensitive aspect of NHS performance would outflank opposition to our longer-term initiatives to sharpen up the financial and managment performance of the NHS.

I am confident from our contacts with the private sector in England and Wales that it would be able and willing to tender to carry out these operations. For instance, we might over a period of a year contract for an additional 400-500 hip relacement operations: not much more than one a day. It might cost some £2,500-£3,000 each, a total of some £1-£1.5 million. We might also expect to attract tenders from health authorities on the basis of their mobilising key staff to work additional sessions.

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If this approach is agreed, I intend to move quickly to a programme of action. I would want also to carry out a detailed analysis of the action and investment necessary to sustain performance against targets in the longer term.

I see access to private capital as fundamental also to our drive to equip the NHS with the information systems and other technologies which will be needed to underpin our reforms. We need therefore to extend the proposed charges to the treatment of capital and open up opportunities for the leasing of medical and IT equipment from the private sector.

I also agree with Kenneth about the need for a central capital loan fund (I would want to operate my own in Wales) to provide repayable short-term finance. I have to make the point, however, that the potential private capital that could be attracted by land disposals in Wales is, of course, very much less than that in the South-East of England. I would want that to be taken into account in establishing baseline allocations for capital programmes.

I am copying this minute to the Chancellor of the Exchequer, the Secretary of State for Health, the Secretaries of State for Scotland and for Northern Ireland, the Chief Secretary, the Minister of State at the Department of Health, Sir Roy Griffiths, Professor Griffiths and Mr Whitehead in the No 10 policy Unit, and to Mr Wilson in the Cabinet Office.

Keith Davies

13 October 1988

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approved by the Secretary of State
and signed in his absence

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NAT HEALTH:
Expenditure Pt 15