

Institute for Public Policy Research



THE 'MAKE DO AND MEND' HEALTH SERVICE

SOLVING THE NHS' CAPITAL CRISIS

Chris Thomas

September 2019

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SUMMARY

The NHS has had historically low levels of capital investment. Compared to similarly advanced economies in the Organisation for Economic Cooperation and Development (OECD), this country's capital investment has been very low. On average, a person living in the UK has missed out on almost £2,000 since 1975 – the equivalent of approximately £100 billion overall.

Since austerity began, capital investment has fallen off a cliff. Capital budgets have been regularly cut, leaving spend at record low levels compared to comparator countries. This has been driven by the health service's struggles to make ends meet day-to-day, forcing the NHS to use its capital to patch up running costs. Over the last four years, £4 billion has been transferred from the capital allocation.

Though they were bad deals, private finance initiatives (PFI) were the only mechanism that brought enough capital into the health system. During the years it was used extensively, our capital spending peaked; in 2007, it was a record £2.5 billion more than the OECD average. Having a mechanism to filter capital into the system was incredibly useful for the NHS. However, PFI specifically has turned out to be a bad deal – and will eventually cost almost £80 billion for just £13 billion of assets. This report reveals that £55 billion of this debt is still outstanding – representing a huge burden on tight NHS resources if the government does not take action.

The legacy of PFI, coupled with low investment, is harming quality of care for patients. PFI payments are particularly damaging for some trusts, which are paying up to 17 per cent of their annual income on PFI repayments. Given the hard fiscal reality the NHS is operating in, and tight control of deficits, this can only translate into lower-quality patient services – a PFI postcode lottery. Beyond this, trusts are struggling to keep up with maintenance costs. There are now £3 billion worth of critical maintenance issues – including collapsing ceilings and sewage leaks – that the NHS cannot afford to fix and putting staff and service-users at risk.

Future transformation will further be impossible under the current capital regime. Key government ambitions from the NHS long-term plan – around cancer outcomes, care in the community, improving productivity and a digital NHS – all require substantial upfront investment. For instance, despite laudable commitments to create a digital NHS fit for the 21st century, the NHS has the lowest number of CT and MRI scanners in Europe and one of the highest numbers of fax machines. This gulf between ambition and reality is symptomatic of the difficulties it faces in funding large-scale capital upgrades. However, government has neither established how much capital their policy priorities require, nor put in place funding to support transformation in the system.

We need a new settlement to fund capital and support transformation totalling £5.6 billion per year – an 80 per cent uplift. This would align our spending per capita with the average OECD average. Given the preferential rates available to government, this should be financed by public – not private – borrowing. Of this, £4 billion should be made available every year in a transformation fund, to support a much-needed upgrade to our health service infrastructure. Anything less will leave us lagging behind international competitors - with the £2 billion

one-off cash injection (a less than 25 per cent uplift) announced earlier this year a wholly insufficient sum to either ensure safety or improve outcomes. It will neither rectify the current backlog, nor support much-needed transformation projects at scale in the health system.

The NHS capital budget should receive a £5.6 billion annual uplift, sustained over five years (and rising with inflation) between 2020/21 and 2024/25. This should be split into maintenance and transformational funding and come from increased public borrowing.

To help avoid underinvestment in the future, a duty should be placed on the Department of Health and Social Care (DHSC) and NHS England to publish capital impact assessments for major policy initiatives.

The PFI legacy must also be urgently addressed, through a ‘right to enfranchisement’ for the NHS. The NHS will pay over £2 billion this year on PFI – and annual payments have not nearly peaked.. This is only good for PFI equity holders, who have made consistently high profits. Government policy to ban new PFI contracts is welcome, but alone it does nothing to ease the burden of PFI's legacy. We recommend a right of enfranchisement for local NHS trusts, where PFI tenures can be transferred into a freehold tenure through a one-off, standardised payment. This would bring the most toxic deals back into public ownership, and improve financial stability across the NHS.

Primary legislation should be laid to give NHS trusts the ability to bring bad contracts back into public ownership through enfranchisement.

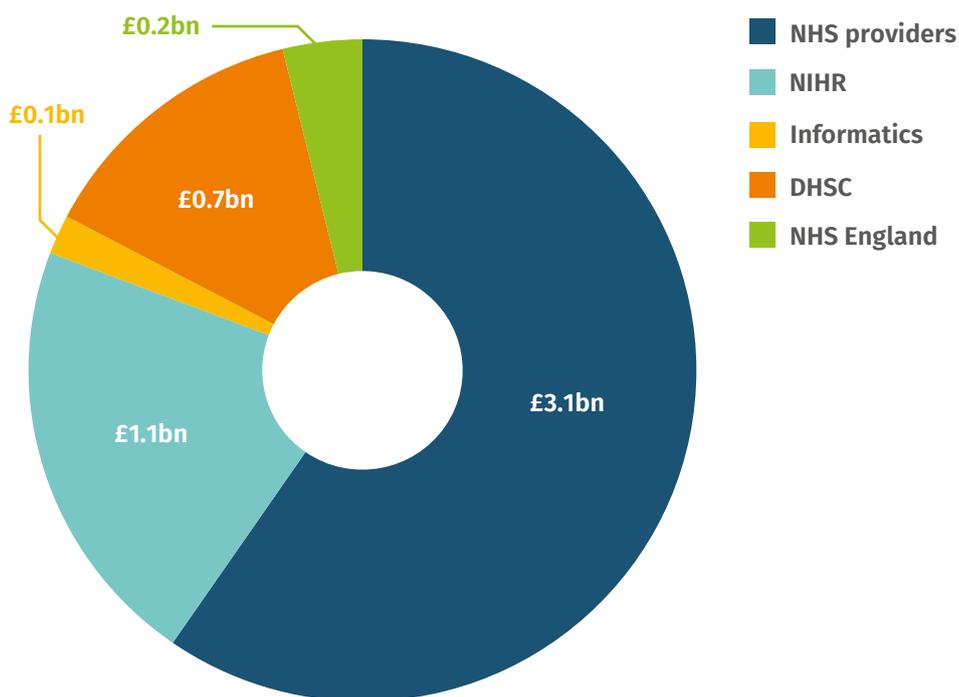
While this is implemented, trusts paying the largest percentage of their income (above the average 5 per cent of income) on PFI should receive direct financial support.

1. CAPITAL NEGLECT

MAKE DO AND MEND: A HISTORY OF UNDERINVESTMENT IN THE NHS

Debates about NHS spending often revolve around the revenue budget. This covers the day-to-day resources and administrative costs of running the health service, and comes to over £120 billion per year (King's Fund 2018). However, the NHS also relies on a second, smaller budget: the 'capital departmental expenditure limit' (CDEL). This pays for long-term investment, including land, the NHS estate, machinery and IT infrastructure. Such capital funding is allocated centrally by the Department of Health and Social Care (DHSC), as shown in figure 1.1.

FIGURE 1.1: THE HEALTH CAPITAL BUDGET FUNDS SEVERAL CRITICAL HEALTH FUNCTIONS
DHSC capital funding distribution 2017/18 (£bn, 2018 prices)



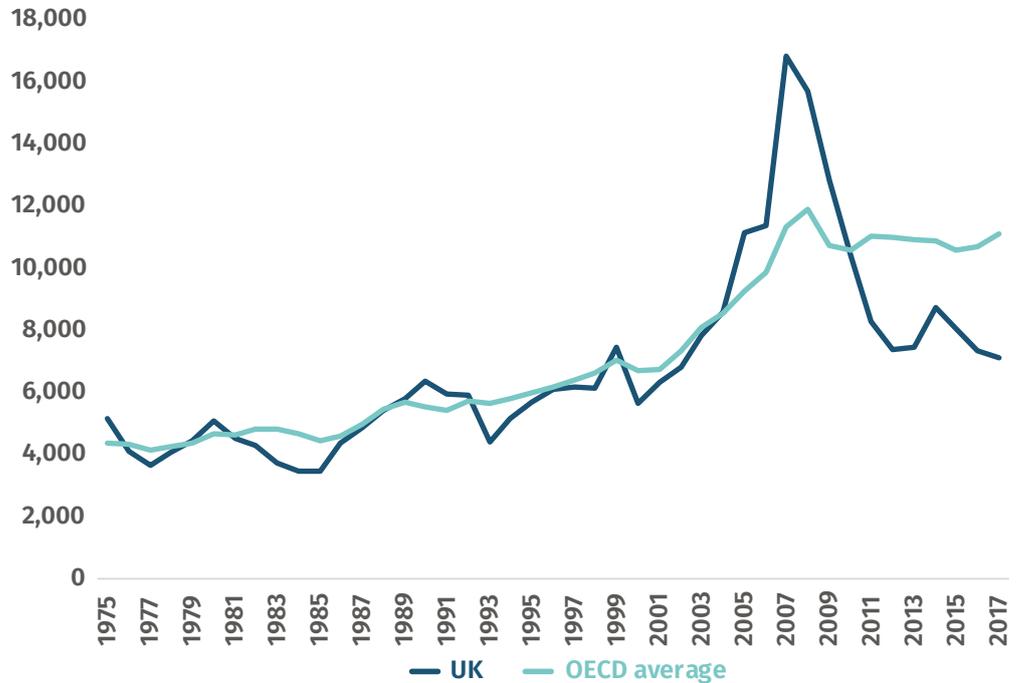
Source: Recreated from The Health Foundation (Kraindler 2019)

The NHS's recent history has been defined by very low capital investment.¹ Indeed, since 1975, the UK has rarely spent above the OECD average on capital in healthcare – a level that would be relatively unambitious given the size of its population and economy.

¹ This paper only considers public sector capital investment, which makes up the vast majority of capital investment in the UK health system.

FIGURE 1.2: UK CAPITAL SPEND HAS BEEN CONSISTENTLY LOW COMPARED TO OTHER ADVANCED ECONOMIES

Capital formation in the UK compared to the OECD average (\$m in constant spend)²



Source: Author's analysis of OECD 2018

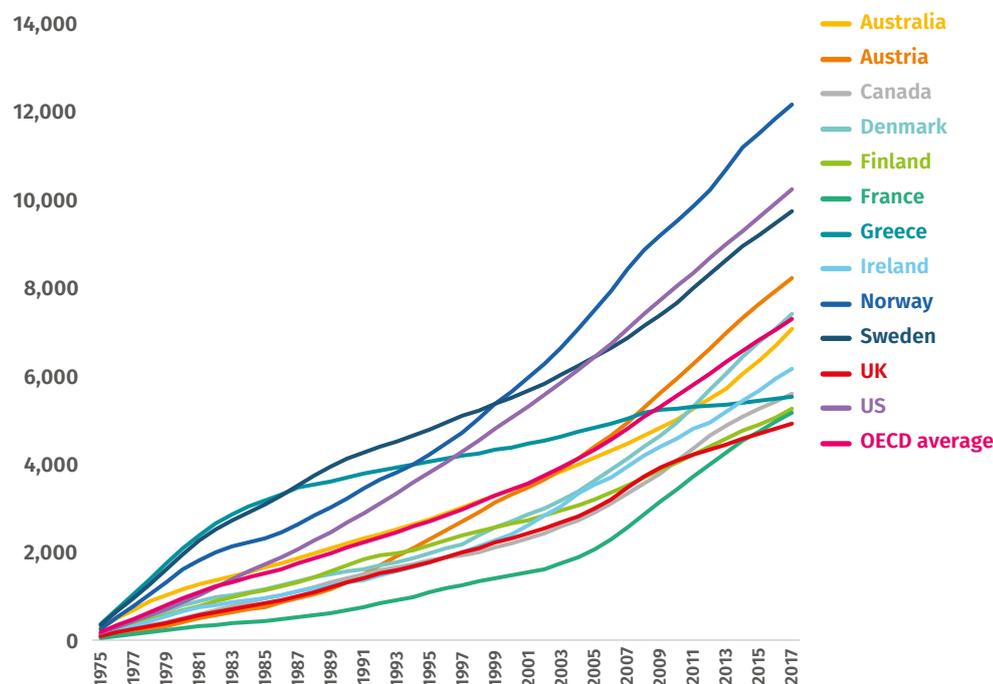
This trend is maintained when controlling for population size (figure 1.3): indeed, the UK invests the least on capital per head across the OECD. When calculated cumulatively, and converted to GDP,³ the average person in the UK has lost out on £1,839 compared to the average person in other OECD nations since 1975. Compared to the country that invests the most per person in health capital (Norway), the average UK resident has lost out on an even more substantial £5,622 per person. Given that England's population stands at 55,977,000 (ONS 2018), this represents a total loss of approximately £100 billion in investment compared to the average and over £300 billion compared to Norway.

² There are minor differences in capital formation (OECD figures) and capital budget (DHSC figures). The most significant is that not all R&D is listed as capital formation by the OECD – however, this is consistent across all countries.

³ Using the 2017 exchange rate (OECD 2019).

FIGURE 1.3: IN THE LAST 50 YEARS, THE UK HAS INVESTED £100 BILLION LESS THAN THE AVERAGE INTO HEALTH CAPITAL

Cumulative capital formation per person by OECD country (\$ in constant spend), 1975–2017



Source: Author's analysis of OECD 2018

A DECADE OF NEGLECT: CAPITAL SPEND DURING AUSTERITY

The UK's approach to health capital has further deteriorated over the last decade. DHSC accounts show cuts to five of the last seven capital budgets (see table 1.1). However, the budget as allocated is only half the story. In the last five years, large amounts of the capital budget have not translated into capital spend. This is largely because revenue pressures – driven by austerity and the lack of a sustainable funding solution for the NHS pre-2018 – saw capital funding redirected from long-term investment and into day-to-day running costs. This practice is called a 'capital to revenue transfer'.

TABLE 1.1: DEPARTMENT OF HEALTH AND SOCIAL CARE CAPITAL SPEND BUDGETS

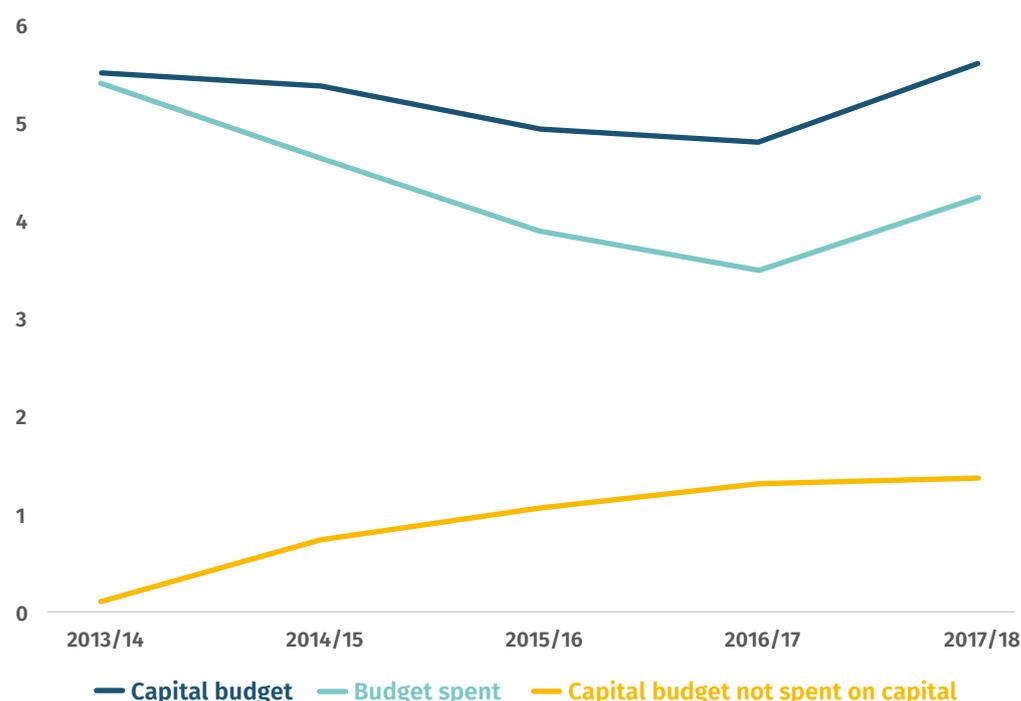
Year	DHSC capital budget (£bn)	Year-on-year change in capital budget (%)
2010/11	5.8	-
2011/12	5.3	-8.7%
2012/13	5.2	-1.1%
2013/14	5.8	+11.9%
2014/15	5.3	-8.5%
2015/16	4.9	-7.2%
2016/17	4.7	-4.3%
2017/18	5.3	+12.7%

Source: Recreated from Kraindler 2019

Since capital to revenue transfers first began, £4 billion has been lost from capital budgets through this mechanism (DHSC 2018a). While that £4 billion represents less than 1 per cent of the NHS total revenue budget over those four years, it represents a 20 per cent drop in the NHS' capital budget over that same time period, significantly harming the ability of health service to invest for the future.

FIGURE 1.4: SUBSTANTIAL SUMS HAVE BEEN TRANSFERRED OUT OF AN ALREADY SMALL HEALTH CAPITAL BUDGET

Annual capital budget allocated compared to annual money spent on capital, 2013/14–2017/18 (figures include transfers and underspend, £bn, real terms)



Source: Author's analysis of DHSC 2018a

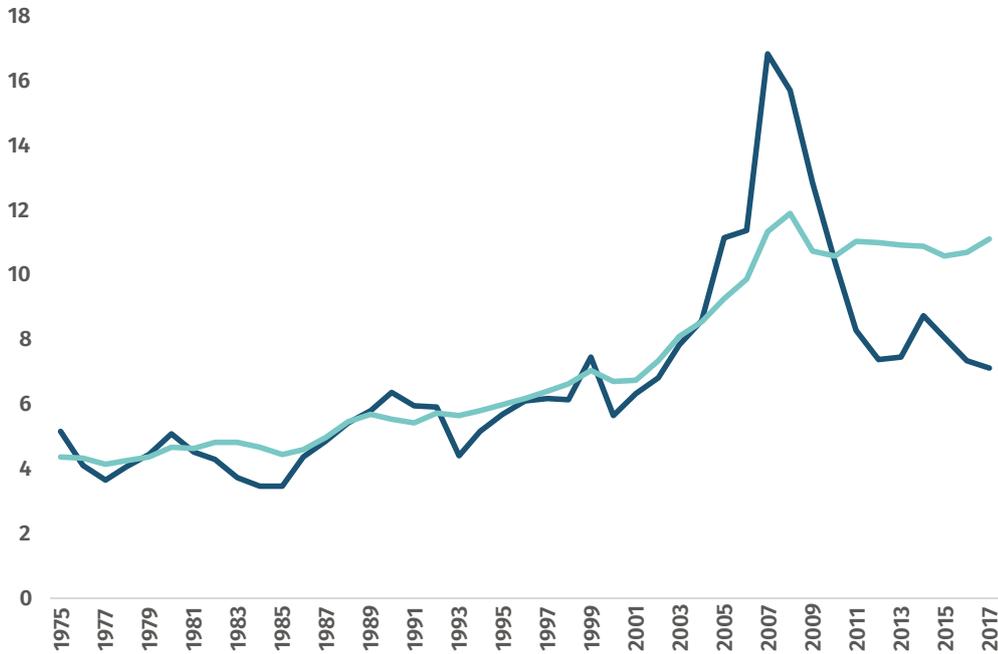
FORCED INTO A BAD DEAL: THE LEGACY OF PRIVATE FINANCE INITIATIVES (PFI)

The UK's health capital spend has only consistently exceeded the OECD average once – between 2005 and 2009. This was achieved through the introduction of PFI. Indeed, in 2007, the UK outspent the OECD average by a record \$5 billion (£2.5 billion, 2007 exchange rate (OECD 2019)), and its decreasing use since 2010 has seen UK capital spend fall to its lowest relative point.

The mechanics of PFI worked as follows. NHS trusts would put out a tender, asking for expressions of interest from contractors to provide new capital assets. These were large-scale projects on the whole – such as the construction of large new hospitals. Bids would come from consortiums, with successful parties forming a 'special purchase vehicle' (SPV). Through this vehicle, the consortium would take out significant debt, which would be used to build the hospital. The NHS would not face any costs until the build was complete. Once it was, they began paying 'unitary payments' – an annual charge to the SPV. In theory, this covered the cost of the capital, the risk taken by the SPV in constructing the site, the interest on the debt, and sometimes other contracted services.

FIGURE 1.5: ONLY PFI INTRODUCED COMPETITIVE LEVELS OF CAPITAL MONEY INTO THE HEALTH SYSTEM

UK capital spend compared to OECD average capital spend, 1975–2017 (\$bn, constant spend)



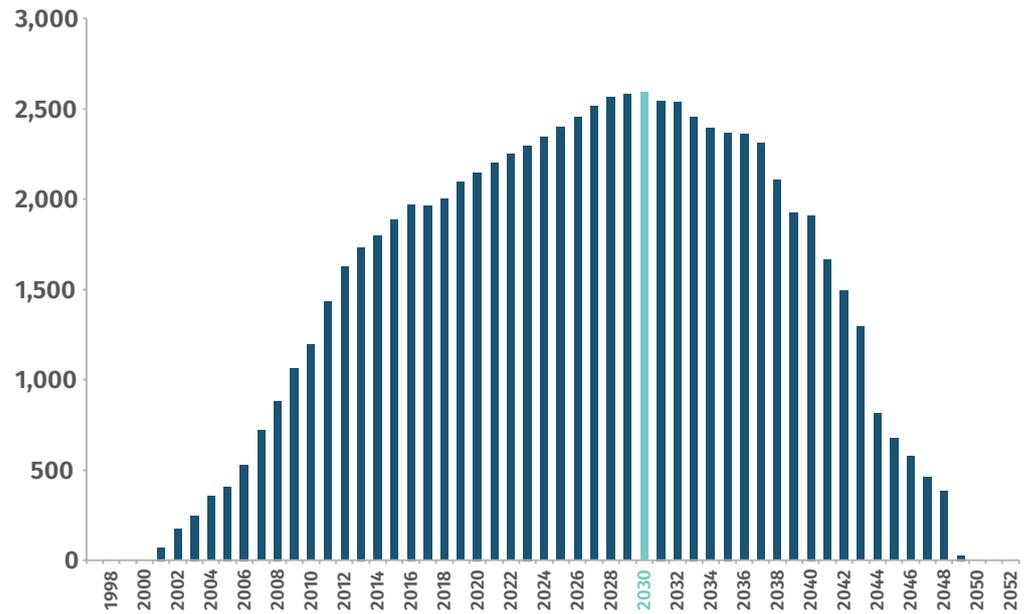
Source: Author's analysis of OECD 2018

The gain for the NHS was the ability to invest in substantial capital projects beyond the department's allocated CDEL. It was also able to outsource the risk associated with large-scale capital investment. In turn, the Treasury did not have to include PFI investment as debt, helping successive governments put their fiscal performance in an artificially good light. Indeed, PFI became a compulsory element of capital investment. As Alan Milburn put it almost immediately after becoming health secretary in 1997: "When there is a limited amount of public-sector capital available... it's PFI or bust" (Monbiot 2007).

There is no doubt that having some mechanism supporting capital investment was valuable for the NHS. However, PFI has ultimately proved particularly poor value for money. The capital acquired, while significant, paled in comparison to the final price the NHS would pay. Over the period it was used, PFI accounted for almost £13 billion of capital investment in the health service (HM Treasury 2018a). In 2019 alone, the NHS will repay over £2 billion in unitary payments – an annual cost that will not peak in cash terms until 2030 (at £2.6 billion per year). The cost of PFI to the health service will ultimately total almost £80 billion and, over 20 years since the first of these contracts was signed, the NHS is still has payments of £55 billion outstanding.

FIGURE 1.6: THE NHS PAYS SUBSTANTIAL ANNUAL SUMS TO PFI SCHEMES EVERY YEAR

Yearly unitary charges owed by the NHS through PFI contracts (£m, cash terms), 1997–2052



Source: Author’s analysis of HM Treasury PFI accountability data 2018

PFI contracts do also include some maintenance and service costs. While these are small relative to the total cost of PFI, they represent another case of poor value for money. During the Coalition government, David Cameron described a hospital trust that was charged £330 by their PFI contractor to change a light bulb (Adams 2018). The idea of this kind of ‘PFI premium’ is supported by new IPPR analysis of NHS estate returns data. A comparison between spend on services per square meter in PFI NHS sites and NHS freehold sites in 2017/18 shows an extra 15 per cent cost for PFI services. This is despite the expectation PFI costs would be cheaper – either because they are larger (economies of scale) or newer.

TABLE 1.2: COMPARISON OF FEES PAID FOR SERVICES AND MAINTENANCE COMPARING NHS FREEHOLD AND PFI ESTATES 2017/18⁴

Contract type	Average/square metre of site
Freehold	£229
PFI	£264

Source: Author’s analysis of ‘Estates Return Information Collection Data’, NHS Improvement 2018

⁴ The average cost a trust pays for all service and maintenance, excluding financial costs. Due to lack of comparable data, money made through car parks and similar – which may benefit freeholders further – have been excluded from analysis, potentially making this estimate conservative. Square meters are based on occupied floor space.

THE 'PFI POSTCODE LOTTERY'

In 2018, the chancellor announced that PFI was dead (O'Shaughnessy 2018). However, the government did nothing to subsequently address the impact of legacy PFI contracts. While these have been shown to earn significant profits for their investors (CHPI 2017), they remain a constant risk to the NHS' fiscal stability. The health service needs relief from high unitary payments and a new mechanism to bring capital money into the system.

There is large variation in where PFI payments most damagingly impact trust finances. Trusts with PFI contracts worth £300 million or more (in capital value of the asset at the time it was contracted) spend as much as 17 per cent of their annual income on PFI payments (see table 1.3). This represents a 'PFI postcode lottery' where some trusts, and their service users, bear disproportionate capital cost. Furthermore, these costs are being borne by those trusts with the biggest PFI contracts; while the average annual PFI payment costs a trust 5 per cent of its income, all but one of the 15 trusts with the largest contracts pay more than that. Though it is possible that some of these costs are offset by productivity gains from new assets, this is unlikely to counterbalance such extensive cost – and represents a significantly greater burden than would have occurred through public financing.

TABLE 1.3: DETAILS OF NHS PFI CONTRACTS WITH CAPITAL VALUES OF £300 MILLION, COMPARED TO INCOMES OF RESPECTIVE NHS TRUSTS

Procuring trust	Capital value of PFI schemes (£m)	Unitary payment (2018/19, £m)	Unitary payment as a % of net income ⁵
Sherwood Forest	326	50.3	16.51
University Hospitals Coventry	378.9	89.3	14.16
St Helens and Knowsley	338	51	13.29
North West Anglia NHS Trust	416	48.6	11.56
Derby Hospitals	312.2	59	10.90
Manchester University	512	77.2	9.33
University Hospitals of North Midlands	415.1	61.9	8.88
North Bristol	430	48.9	8.57
Mid Yorkshire	311.5	41.4	8.19
Barts' Health	1184	116	7.66
Oxford University	300	70.3	6.83
University Hospital Birmingham	625	57.1	6.66
Royal Liverpool	329.4	29.1	5.65
Maidstone and Tunbridge Wells	302	24.8	5.63
Sandwell and West Birmingham	333.7	18.3	3.70

Source: Author's analysis of individual trust accounts 2018 and HM Treasury 2018a

⁵ Taken from the annual accounts of respective trusts from 2017/18. Where trusts have merged, individual accounts rather than group accounts have been used. All completed PFI contracts have been excluded from analysis.

2. CAPITAL: WHAT IS IT GOOD FOR?

The NHS will face substantial challenges in the coming decades. An ageing population means that long-term conditions are becoming more prevalent (DHSC 2012). Almost one-quarter of our population have multiple conditions – a trend that is on the rise (Stafford 2018). Average life expectancy is stalling across the UK, and even falling for those living in the poorest places (Raleigh 2018).

But these challenges are not destiny, and should not inspire fatalism about our ability to provide equitable, high quality and universal health care (Darzi et al 2018). Doing so will require the right investment – including capital investment in the right estate, the right number of bed space, in primary facilities, in the best digital and self-management tools, in AI, robotics, and software licences.

As it stands, however, the NHS enters the next decade constrained by PFI payments, with a decade of austerity-led cuts to its PFI budget and without any mechanism to funnel money into capital investment. This section details some of the ways in which this will undercut the transformation needed to meet future challenges head-on, particularly by preventing delivery of the NHS long-term plan for England.

WORLD-LEADING CANCER OUTCOMES WERE A KEY TRANSFORMATION TARGET IN THE NHS LONG-TERM PLAN. THIS WILL NOT BE POSSIBLE WITHOUT CAPITAL INVESTMENT

The NHS long-term plan made some bold commitments on diagnosing patients earlier: **“This long-term plan sets a new ambition that, by 2028, the proportion of cancers diagnosed at stages 1 and 2 will rise from around half now to three-quarters of cancer patients”** (NHS England 2018). NHS England predicts that this would increase five-year cancer survival by 55,000 per year.

The plan to achieve these gains focusses on modernisation of diagnostics and new screening programmes for lung, bowel and cervical cancer. However, the long-term plan makes no specific commitments on diagnostic capacity, which remains one of the most significant challenges to early diagnosis of cancer.

In parallel, a 2018 study by Cancer Research UK shows that waiting times for tests are increasing – and that demand is putting substantial pressure on services (Cancer Research UK 2018). More recently, the Health Foundation has shown that the UK has the lowest number of CT and MRI scanners per million people in the OECD. This is directly related to the capital spend budgets that the NHS has access to – and would cost £1.5 billion to rectify (Kraindler 2019).

Furthermore, NHS waiting times for tests have substantially increased, with more than three times as many patients waiting six months for a diagnostic test in 2016/17 than in 2008/09 (CRUK 2018).

More capacity is urgently needed, in the form of more and newer machinery. Without it, the NHS will simply not have enough capacity to fulfil its ambitions.

More than that, it will struggle with the kind of service improvements it has committed to – including the move towards rapid diagnostic centres, which will clearly require the right equipment in place from the outset.

NHS TRANSFORMATION RELIES ON A DIGITAL NHS FIT FOR THE FUTURE – INCLUDING THE CAPITAL FUNDING FOR THE INITIAL DIGITAL INFRASTRUCTURE

A whole chapter in the long-term plan was dedicated to digital, with a headline commitment to make **“digitally enabled care... go mainstream across the NHS”** (NHS England 2018).

The ambition is laudable and the potential gains from this kind of digital upgrade substantial. Research shows a clear link between greater adoption of technology and improvements in quality, efficiency and health outcomes (Imison 2016). There is also a role for technology in supporting people to self-manage their own care and in improving safe care (by reducing avoidable errors) (NHS Improvement 2009). Technology further helps improve data, creating a virtuous cycle of improvements to service planning (Imison 2016).

However, far from enough consideration has been given to capital. The NHS has a record of struggling to replace its technology, most notably its continued reliance on fax machines through this decade – leading to a total ban on new purchases by the secretary of state in 2018 (DHSC 2018b). Compared to the rest of Europe, the NHS keeps assets for much longer (Kraindler 2019).

A key reason for this is that upgrading these kinds of assets is best done at scale (there is little point being the only hospital with email if fax is used everywhere else). This would need significant access to capital – for the machines, software licences and technology needed by the 7,454 GP practices, 207 clinical commissioning groups (CCGs), 152 acute trusts, 54 mental health trusts, 35 community providers and 10 ambulance trusts that make up the ‘national’ health service. This lack of planning for upfront, capital investment has been a stumbling block for previous enthusiastic commitments to ‘a digital NHS’ (Honeyman 2016).

It is unrealistic for us to expect the UK to be a leader in digital without investment. And as the Health Foundation have noted, IT capital spend is only a punishingly small proportion of the total capital budget (5 per cent) – and that budget is already significantly below the OECD average. NHS England will need to overcome this barrier before a ‘digital NHS’ can become a reality for the service and its users.

A SHIFT TO MANAGING CONDITIONS IN THE COMMUNITY WILL NOT WORK WITHOUT FIT-FOR-PURPOSE CARE SETTINGS

The long-term plan has high expectations for the gains possible through primary and community care, committing at least £4.5 billion of additional revenue spend to these sectors over the next five years. This is intended to fund expanded community teams aligned with community networks and fully integrated community-based health care.

As the above commitment acknowledges, there are significant benefits associated with investment in primary and community care. They deliver on a pressing need for services to be more closely connected – both to each other and to the needs of their population (Charles 2018). They have also been recommended for the management of long-term conditions after diagnosis (Moyez 2008), particularly in the case of multiple conditions (The Richmond Group 2018).

However, there are again no answers to pressing questions on capital that exist. Integration requires investment in interoperability – allowing software to talk to each other across care settings. In the first instance, this at least requires bringing everyone up to a common standard of software and software licences. Equally, it requires substantial improvements to data. It is incredibly difficult to provide high-quality integrated care without a sense of how the patient uses services, what the efficacy is for different groups, and what population need looks like across a place or community. Both require upfront capital investment.

Equally, there remains reticence to talk about the community and primary care estate, which has long not been fit for purpose. By far the best model if our ambition really is swift and effective integration is the ‘community hub’ model, which brings key services together within single settings. Again, this requires small amounts of up-front capital investment to work. Examples of how small amounts of capital can go a long way include the funding allocated for the development of primary care hubs by Jeremy Hunt in 2017, which included:

- £5 million to develop a primary care hub in Bedfordshire
- £10–30 million to build an area within Royal Derby Hospital to house GP services, out of hours support and mental health assessment services
- £5 million of capital funding to support eight Integrated Care Communities in West, North and East Cumbria (House of Commons 2017).

Primary and community care is a central pillar in delivering the outcomes that government expects from its £20.5 billion investment into the NHS revenue budget. However, without a corresponding uplift in the capital budget that is accessible across the provider sector, it will be very difficult to realise the full potential of the shift.

PARITY OF ESTEEM BETWEEN PHYSICAL AND MENTAL HEALTH WILL REQUIRE A MORE EQUITABLE DISTRIBUTION OF CAPITAL SPEND

The NHS long-term plan makes mental health a clinical priority – a welcome step towards parity of esteem. But the spaces in which people receive care and the resources available to care givers are both critical to outcomes and reliant on capital investment, a link that is not adequately described by the plan.

The consequences of low capital investment, detached from levels of need, can be seen throughout the NHS’ mental health services. For example, the Care Quality Commission have highlighted the problems with sexual safety on mental health wards. This is – at least to some extent – driven by the ability to provide a fit-for-purpose estate, leading to practices like dormitory accommodation continuing to the detriment of service users’ dignity and safety (CQC 2018).

At the same time, the capital flow into mental health wards is very low. A freedom of information request showed that one-third of mental health trusts did not bid for sustainability and transformation partnership (STP) capital funding (Thomas 2019). Without both funding availability and an awareness of the capital needed within mental health trusts the mental health estate will remain a barrier to parity of esteem.

THE PRODUCTIVITY GAINS NEEDED TO MAINTAIN A SUSTAINABLE HEALTH SERVICE RELY ON CAPITAL INVESTMENT

The government has made clear that it expects a more productive NHS – with a specific target of a 1.1 per cent average gain every year of the long-term plan (Maguire 2019). While the NHS continues to be a highly productive organisation, with gains reported in all but one year since 2002/3 (ibid), more would be possible with greater capital investment.

First, this is because capital spend is critical to ensuring that the workforce have the best possible support. For example, the Health Foundation have recently shown that ‘capital thinning’ (a reduction of capital available per worker) has occurred in the NHS. This is inversely related to productivity; because staff need access to the best equipment, machines or technology to deliver better care at the lowest possible cost (OBR 2018). The overall reduction in capital per worker has been nearly 20 per cent between 2010/11 and 2017/18 (Kraindler 2019)

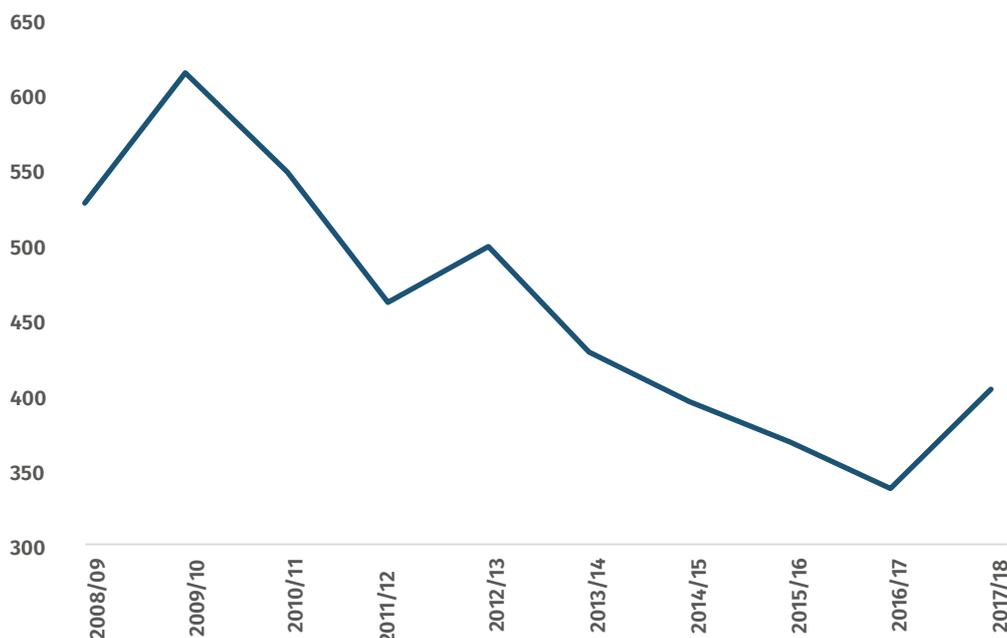
Second, this is because the equipment, buildings, technology and machines staff use in a capital-intensive workplace like the NHS depreciate in quality and value over time. Qualitative research has shown a high number of trusts reporting that equipment failures – as well as shortages – impact the productivity of both their clinical and non-clinical teams (Williams 2018).

TRANSFORMATION ASIDE, CURRENT CAPITAL LEVELS ARE SO LOW THEY THREATEN BASIC PATIENT SAFETY

The significant fall in capital budgets seen since 2010 strongly corresponds to decreasing capacity in hospital trusts to invest in their maintenance backlogs.

FIGURE 2.1: AS CAPITAL BUDGETS HAVE BEEN CUT, INVESTMENT IN NECESSARY MAINTENANCE HAS FALLEN SHARPLY

Investment in maintenance backlog 2008/09 to 2017/18 (£m, real terms)



Source: Author’s analysis of NHS Digital 2018

This has driven substantial increases in high risk and significant risk maintenance – up to over £3 billion in 2017/18 (combined as ‘urgent maintenance’ in figure 2.2).

FIGURE 2.2: THERE HAS BEEN A SHARP RISE IN THE AMOUNT OF THE HIGHEST RISK MAINTENANCE ACROSS THE NHS ESTATE

Maintenance backlog by risk level (£bn)



Source: Author's analysis of NHS Digital 2018

This is a direct threat to patient care. Such maintenance covers instances where: “repairs/replacement must be addressed with urgent priority in order to prevent catastrophic failure, major disruption to clinical services or deficiencies in safety liable to cause serious injury and/or prosecution” (NHS Digital 2017). It includes threats to buildings, as well as patient and worker safety including but not limited to:

- collapsing ceilings
- sewage leaks on wards
- broken lifts delaying patient transfers
- unusable machines, including diagnostic tools for cancer
- poor fire safety.

This risks patient safety, NHS building regulations, staff wellbeing and our confidence in providing a modern standard of health provision.

3.

A CAPITAL FUNDING SETTLEMENT TO TRANSFORM THE 'MAKE DO AND MEND' NHS

Figures like the one-off approximately £2 billion announced by the chancellor in the most recent spending round do not nearly give a sustainable solution to a capital crisis five decades in the making (HM Treasury 2019). It will neither clear the most severe maintenance problems in the NHS estate (as in figure 2.2), nor provide the long-term certainty needed to effectively manage transformation. Any settlement must look to both rectify historical poor performance and give trusts the long-term funding security they need to effectively manage transformation processes.

To truly end the 'make do and mend' nature of the NHS in 2019, government should urgently correct for our comparative underspend per person (as a proxy for the capital we need as a population) when compared to other advanced economies. In the first instance, government should aim to bring our spending in line with the OECD average – a relatively unambitious target. In the most recent data, the OECD average spend per person was \$241. The UK spent significantly less – \$107 per person (OECD 2018). Given the current population estimate for England (ONS 2018) and converting this to GBP (most recent exchange rate (OECD 2019)), matching the average capital spend per person would require an uplift in spending in this country of £5.6 billion, maintained and rising with inflation thereafter.

This should be split into maintenance and transformation funds.

- **Maintenance:** This should include an explicit commitment to clearing high and significant risk maintenance at a cost of £3 billion by the end of the settlement period (see figure 2.2). It should also include a return of investment in the maintenance backlog – equivalent to £210 million in year one. Rising with inflation, this would cost £1.1 billion over the period. Finally, a buffer (at 7.5 per cent) should be introduced to restrict the impact of underspend – a historical problem linked to tight fiscal regulation of the NHS.
- **Transformation:** All additional funding – totalling £4 billion in year one (and slightly more thereafter) – should be made available for a long-term capital transformation fund. This is broadly in line with the range of estimates others have suggested for a successful transformation process – and is likely to have a long-term return on investment (King's Fund 2015). Transformation funding should support a place-based approach to NHS reform – with capital budgets devolved to local areas (such as integrated care systems) - and should be allocated through a bidding process based on the potential to unlock improvements in care and efficiency through transformation. It is critical that this process is timely and transparent – traits lacking from the current allocation process.

Overall, this new settlement would mean a DHSC CDEL⁶ budget as shown in table 3.1.

TABLE 3.1: IPPR RECOMMENDATIONS ON A FIVE-YEAR CAPITAL SETTLEMENT FOR DHSC

	2020/21	2021/22	2022/23	2023/24	2024/25
Recommended DHSC CDEL (£bn)	12.3	12.5	12.8	13.1	13.3

Source: Author's analysis

In looking to find the funding for this capital settlement, we should learn the lessons of the past. Government interest rates are significantly lower than those associated with PFI schemes. Furthermore, as IPPR have shown elsewhere, the UK government can sustainably borrow more money as public debt. As a country, we have substantial fiscal headroom – especially when this extra borrowing is used to fund investment (Quilter-Pinner and Hochlaf 2019). We therefore recommend that all new capital should be funded through government borrowing.

From this settlement, government should consider how it allocates capital in the future. Currently, no mechanism exists to link the capital allocated to the capital needed in the health system. A duty should be introduced on DHSC and NHS England to publish the capital requirements of major policy announcements, to ensure transparency over the funding needed and the funding available. This would support the Treasury's decisions on future CDEL allocations and introduce accountability where insufficient sums are provided.

Policy recommendation one

The NHS capital budget should receive a £5.6 billion uplift per year, sustained over five years (and rising with inflation) between 2020/21 and 2024/25. This should be split into maintenance and transformational funding.

Policy recommendation two

The maintenance uplift to providers should be allocated from the centre based on need and should both address all 'urgent risk' maintenance backlog, and bring investment in maintenance back to its peak. Transformation funding should be devolved to local areas and allocated through a bidding process based on the potential for transformational improvement, and tangible reductions in the disparities in health outcomes across geographies and socioeconomic groups.

Policy recommendation three

Funding for the uplift should come from government borrowing, with current rates significantly preferable to private financing.

Policy recommendation four

Government should introduce a duty on DHSC and NHS England to produce capital implication statements for major policy announcements – though the onus for actually providing the capital should remain with the Treasury.

⁶ Using the figures from the 2018 budget (HM Treasury 2018b) – spend committed since, for example at the recent Comprehensive Spending Review, could be used to contribute towards this uplift

4.

ENDING THE PFI CRISIS

In addition to a realistic funding settlement for capital, it is crucial that we have a reasoned approach to PFI. Doing nothing would leave the NHS – or at least a significant number of NHS trusts – in a poor financial position. At a time of constrained resource, this translates to money being wasted on inefficient contracts, rather than invested in world-class patient care. Several options for tackling this exist.

EXISTING APPROACHES TO PFI

Do nothing on PFI legacy and ban future PFI contracts

This is current government policy. After announcing the end of PFI in the 2018 autumn budget, no action has been taken on legacy PFI contracts. The National Audit Office report on PFI makes clear that this even includes providing the funding necessary for trusts who both can and want to activate break clauses in their PFI contract from doing so (NAO 2018). This maintains a cause of severe financial stress on the NHS and reinforces the PFI postcode lottery, while also giving a weak signal to the market about government willingness to intervene on behalf of the NHS.

A windfall tax on benefactors of PFI payments

A group of cross-party MPs recently proposed the introduction of windfall tax on major PFI contractors – intended to exclude them from any savings associated with the Treasury's reduction of corporation tax from 30 per cent to 19 per cent (Perkins 2018).⁷ In theory, this tax would either raise revenue or encourage renegotiation of the most toxic contracts. Those introducing the bill signalled a strong hope for the latter.

However, there are justified fears that this approach does not go far enough. PFI generated significant profits through onerous terms. It is unlikely that a tax rise of 10 per cent would encourage renegotiations of the scale needed to mitigate PFI's toxic impact. If government's aim was to renegotiate or replace all of the PFI contracts that do not offer value for money for the state, there are more direct interventions that do not rely on incentives and behaviour but instead mandate a change in terms.

Full nationalisation of PFI

Nationalising PFI has perhaps been the most radical proposal to the PFI problem (Pickard and Plimmer 2017). Nationalisation would involve buying the SPVs at market prices – at a cost of approximately £2.6 billion (Kotecha and Holloway 2018). This cost appears relatively low, mostly due to many SPVs having negative book values, but government would also take on the SPVs' debt (around 90 per cent of all PFI buildings are funded through debt). The idea is that they could then refinance this debt at preferential public borrowing rates, reducing the overall cost.

This is a strong approach, which tackles the issues of PFI head on and provides a clear path to providing the NHS with fiscal relief. However, it does come with

⁷ The bill was defeated 305 to 265.

two downsides. Firstly, it is likely to be controversial and may face significant political challenges. Equally, although it seems to have legal grounds, SPVs will have every incentive to delay the legislation through legal challenges. Without a government with a clear commitment to this course of action and a large majority, delays could take us far beyond the year PFI payments will peak (2030) and uncomfortably close to when PFI payments will finish (2048). This would undercut prospective savings significantly.

Secondly, and perhaps more importantly, nationalisation is a relatively blunt approach. Through PFI was mostly a bad deal, some contracts do work – and there are trusts that would choose to maintain their contract (indicatively 10 per cent of trusts) (NAO 2018). Nationalising these does not make fiscal sense and would detract from local financial autonomy within the NHS, which is likely to be unpopular with the provider sector. A more selective, localist approach may be preferable as a solution to the issues PFI raises.

A RADICAL END TO THE PFI CRISIS

Enfranchisement (selective nationalisation)

The government could decide to legislate for a public sector right to enfranchisement, targeted at the most toxic PFI contracts. This approach builds on the precedents set by government action on unfair contracts – in the case of payday lenders, PPI policies and more recently on leasehold (MHCLG 2017).

The closest comparison is the government's action on leasehold. People who had purchased a house found themselves locked into contracts with high management costs and onerous ground rents payable annually – a situation similar to the NHS' experience of PFI. Government committed to allowing leaseholders to buy their freehold at a set price, using a fixed formula.

A consistent and proportionate approach would see public sector bodies given the right to buy out their PFI contract. This would require primary legislation, giving a right to change tenancy for a price set by the introduction of a technical formula. The formula should account for: the current market value of the asset, the amount paid so far by a trust, the percentage of debt owed by the SPV, the years remaining on the contract to date, and a discount rate, based on the future value of the asset.

There are some differences between this and housing enfranchisement, because PFI is considered a tenure in its own right. But the necessary solution is similar – a mechanism through which the NHS can change its tenancy and restore control over its land, by reclaiming full right to its freehold at a consistent and transparent price.

Government could choose to legislate a right to enfranchisement where, after a fixed payment had been made, SPVs retained their debt liability. There is some precedent here: a consumer buying a house or changing their tenancy would never be liable for the way their property was funded, including if the constructor had funded construction through high-interest loans. This option would be significantly cheaper for government, particularly when compared to nationalisation. However, it comes with a risk: SPVs are limited liability companies and would likely immediately bankrupt, passing on bad debt to third party banks and private individuals.

Alternatively, government could take over the debt (fully discounting the price paid for the asset accordingly). This could be preferable, if only because it will

not affect third parties and will allow legislation to proceed more quickly. As with nationalisation, the government would then look to refinance the acquired debt.

The main advantage to enfranchisement is that it is both localist and selective. Analysts have rightly noted that PFI contracts became better value as the NHS improved their private procurement processes (Appleby 2017). Where contracts are acceptable to trusts, enfranchisement allows them to continue. Where deals are bad value or exploitative in nature, enfranchisement gives them a clear right to bring them back into public ownership. It brings bad deals back into public ownership, while maintaining the financial autonomy of NHS trusts and providing cost savings when compared to a more generalist approach to nationalisation.

Such a process aligns with appetite within trusts, of whom 90 per cent told the National Audit Office that they'd be interested in buying out their contract (NAO 2018). Only two have currently done so. Where they have, they have reported significant savings, such as £1.4 million per year in Tees Esk and Wear (Appleby 2017).

TABLE 4.1: SUMMARY OF POLICY OPTIONS

Policy	Government cost	NHS saving	Timescale	Recommended?
Do nothing	None, beyond the significant opportunity cost.	None	N/A	No
Centralise costs	Neutral, as costs are already being borne.	Neutral: Costs already exist. But it does make those costs more equitable.	Immediate, through the next fiscal event.	Yes, on a temporary basis until more significant legislation can be implemented.
Windfall tax	Low: This is behavioural and may generate some small amounts for the exchequer.	Low: Only those nudged will be incentivised to renegotiate, but many private stakeholders are making sufficient profits to hold firm.	High: This has already been defeated and may be difficult to implement in a sufficiently targeted way.	No
Nationalise	Moderate: It covers all PFI schemes, so may be higher cost than other options. However, some SPVs have negative book values, reducing the cost.	Moderate: NHS will save on poor deals but will lose benefit from any deals it feels to be good value. Many SPVs have negative book values, providing a discount on the nationalisation process.	High: Challenge is very likely, both politically and legally. If delays run into years, this could prove costly to the NHS, who will continue to pay unitary payments in excess of £2 billion per annum.	No
Enfranchise	Moderate: It needs to fund buyouts of all deals and oversee legislation.	High: Good PFI deals are retained, and bad deals can be bought out for market value of the asset (not the company controlling the asset).	Moderate: There is likely to be less challenge than with nationalisation, as it only targets toxic contracts and is comparable to existing government policy.	Yes, as a process for 'selective nationalisation'.

Source: Author's analysis

Policy recommendation five

Government should legislate for a public sector right to enfranchisement which would allow those trusts who want to buy themselves out of PFI contracts. This should be supported by a specific contract management team in DHSC.

Policy recommendation six

Government should pay all PFI payments that exceed 5 per cent of a trust's annual income centrally for a limited period, to end geographical variation in the time before the above legislation is laid.

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