The credit crisis and health care

With the current financial turmoil affecting the cash flow of governments, business, and individuals, **John Appleby** assesses the likely effect on the NHS

It is hard to resist apocalyptic phrases (indeed, the use of the word apocalyptic) in describing the effect of the credit crunch on the world's banking and financial systems over the past year. But it is not just the somewhat unreal and mystifying world of credit default swaps, naked short selling, and eye-watering bonuses that has been affected. As has become much clearer in the past few months the scale of the seizure in wholesale credit markets is such that the effects are being felt in the real world.

As the government commits potentially hundreds of billions of pounds to supporting banks and guaranteeing depositors over the next few years, borrowing huge amounts in the process and pushing national debt to over half the UK's gross domestic product, it is hard not to foresee some effect on public services. What, then, might be the immediate and longer term prospects for the National Health Service and, indeed, the nation's health?

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As the speed and scale of the unfurling of the credit crunch has shown, predicting the future is not an easy task—even for those with a substantial personal financial risk at stake. Nevertheless, the short (and short term) answer to the question of the direct effect of the crisis on the NHS is that it will, with some qualified hedging, be minimal. However, the longer (and longer term) answer is more complicated.

SHORT TERM

Scarce credit and lost deposits?

In the short term the credit crunch will affect public organisations with deposits in commercial banks and reduce the ability of private sector health providers to borrow to fund developments. Already there is evidence of cutbacks in the private sector. Virgin Healthcare, for example, announced in September that, "Given the current economic conditions and the challenges within the sector we have decided to measure our pace and to evaluate a broader range of entry options."[1] In other words it does not see its particular business model working under current economic conditions.

How other private sector suppliers to the NHS will be affected is unclear. But presumably there will be a slow down in, for example, future private finance initiative schemes. The turmoil in the banking system may also affect charitable healthcare providers. Naomi House children's hospice in Winchester, for example, faces the potential loss of nearly £6m (€8m; $10m) it has invested in the troubled Icelandic bank Kaupthing Singer and Friedlander.[2]

The problems with the Icelandic banking system may also affect local authorities' commissioning of social and healthcare services from the voluntary sector as about 100 councils in England, Scotland, and Wales have deposits in collapsed Icelandic banks worth around £843m. Fortunately, most NHS

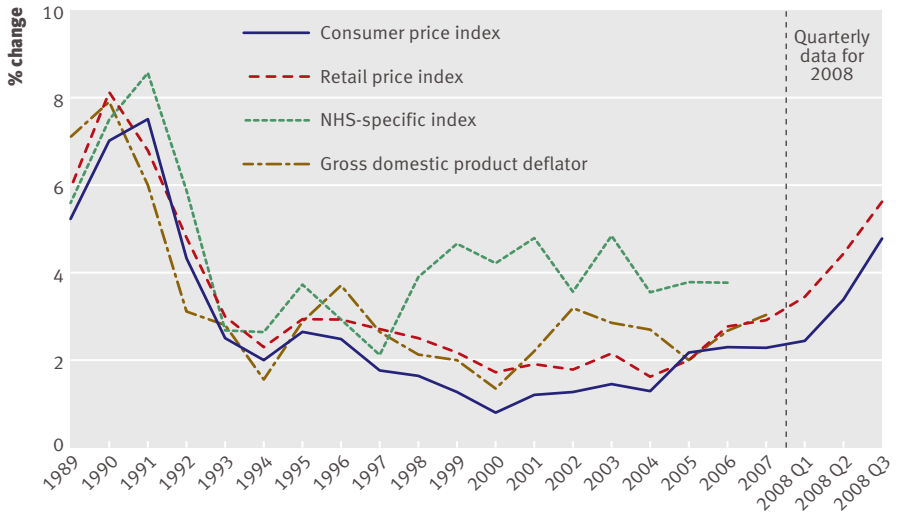

Fig 1 | Percentage annual changes in UK inflation using different measures, 1989-2008[7-10]

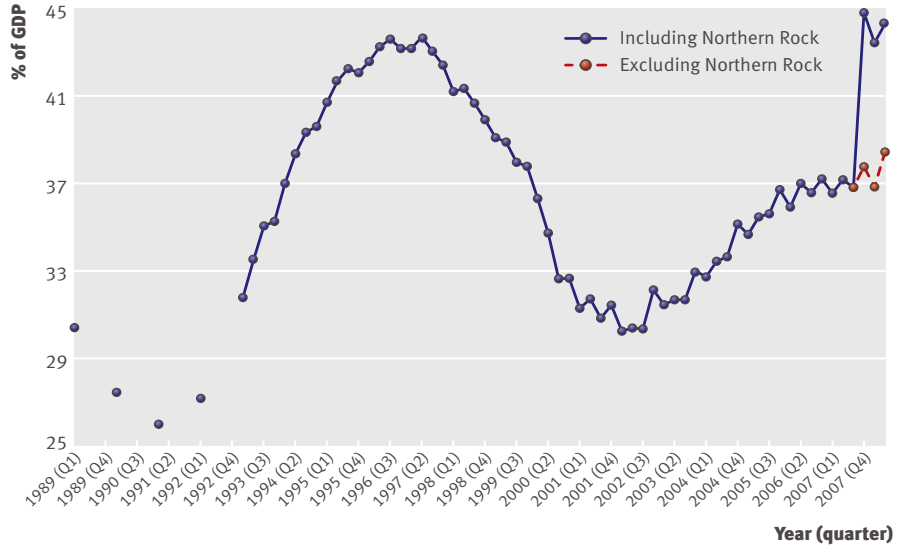

Fig 2 | Net debt of UK public sector[15]

organisations are not allowed to use the commercial banking sector for depositing cash to earn interest. NHS trusts, primary care trusts, and strategic health authorities use the government's own bank—in the form of the Office of Her Majesty's Paymaster General.[3] However, foundation trusts can invest operating and surplus cash in the commercial sector if they choose (they can also use the Paymaster General).

At least two foundation trusts have reported to their regulator, Monitor, that they have funds at risk in Icelandic banks totalling around £2m, with the Christie Hospital in Manchester having a further £6.5m of charitable funds invested in Kaupthing Singer and Friedlander.[4] Monitor states that the potential loss of this money would not contravene the terms of their authorisation or affect services to patients. Of course, if they do lose this money it's money that will not be spent on patient services. Monitor has issued guidance on such cash deposits, suggesting, for example, using banks with minimal risk ratings and setting maximum deposits in any one account.[5] Overall, then, in terms of direct exposure to banking failure from the credit crunch, the NHS should face little danger.

SHORT TO MEDIUM TERM

Inflation and claw backs?

Over the next year and up to the end of the current comprehensive spending review settlement in 2011, the NHS's disposable income may be eroded through inflation rises and possible Treasury claw backs of any surpluses.

Inflation measured by the consumer price index, the measure the Bank of England's monetary policy committee focuses on, is edging towards 5% (3% above the committee's target). The retail price index, however, was nudging 6% in the third quarter of this year—the highest since 1991. The monetary policy committee predicts that inflation will peak next year and then start to come down (partly because of recessionary forces gathering pace).[6] As figure 1 indicates, NHS inflation tends to be slightly higher than inflation in the economy as a whole, and every 1% increase costs the NHS around £380m.

Increasing retail prices will also put pressure on NHS staff's disposable incomes and could encourage higher wage claims, which again (in the absence of productivity improvements) reduces spending on increasing the volume and quality of patient care. Staff covered by the Agenda for Change pay deal (most of the workforce) have an agreed three year pay deal to 2010-11.[11] But with inflation currently at around 5% a year and the deal worth around half that, there may be pressures for renegotiation. As general practitioners have had no real rise for two years and consultants only low increases, more generous pay deals may also be difficult to maintain if inflation remains at current levels. However, most forecasts predict a fairly sharp reduction in inflation next year—back to around 2%—so the government will strongly resist any claim for pay rises over current deals.

NHS income may, however, be under threat from the Treasury. Currently the NHS in England is projecting a year end underspend of around £1.7bn[12] and foundation trusts are reporting cash balances of £2.5bn.[13] These sums are piffling relative to the government's £387bn (around 27% of UK gross domestic product) financial support package. Although the prime minister pledged not to cut spending for health as set out in the 2007 comprehensive

spending review,[14] taking back unspent money may not be seen as a cut. The Treasury has a track record in clawing back underspends from the NHS: it took back an underspend on the NHS capital budget of around £2bn in 2006-7 and redistributed the money to the NHS in the 2007 spending review.

The government may try to maintain if not increase public spending as a tactic to ameliorate falling demand in the economy, but there are probably more effective and direct ways of doing this than through health spending. At the margin, the Treasury is likely to tighten as many spending belts as possible to reduce the effect of current government borrowing commitments (fig 2). Nevertheless, current spending levels are probably guaranteed. The problems may come in the longer term.

LONG TERM

Zero growth and higher demands?

In the longer term, speculation about not only the credit crisis and its aftermath but the effect this will have on the NHS becomes much more difficult. While, potential claw backs aside, NHS spending is guaranteed up to April 2011, what happens after then looks decidedly less rosy.

Government income from tax receipts will be lower than forecast over the next few years or longer, depending on the depth and length of the recession, and government spending to support its borrowing much higher. What was always going to be a tight spending round in 2010 is now extremely tight. At best the NHS might expect no real growth in funding to 2014—a big change over funding trends to date (fig 3) and there will be considerable pressure to cut costs and improve productivity.

But not only will there be pressures on NHS funding, the combined effect of the credit crunch and recession on the population's health and wellbeing will increase ill health and demand on healthcare services. The link between deprivation, income, housing, unemployment, and healthcare needs is well documented, and such factors have been part of the weighted capitation formula used to share out the NHS budget across the country for many years.[17] And current signs and projections are not encouraging. Unemployment, for example, is rising and could reach two million over the next few months. Apart from the health effects of such a rise (and consequent effect on demand for health care), it will also increase pressure on government benefit spending, further limiting options for other public sector spending such as health.

Even if current governmental efforts to get the financial system up and running again succeed (and short term, the signs are ambiguous to say the least) there will be a price to be paid. So far the UK is committing £387bn of a total worldwide package in excess of £1.6 trillion[18]: all of it is taxpayers' and borrowed money. This sum could well increase—right up to the point when the credit worthiness of even governments starts to be called into question. Exactly how, to what extent, and over what period this huge opportunity cost will be born by the NHS is hard to predict, but for now preparation for a difficult financial and health future looks unavoidable.

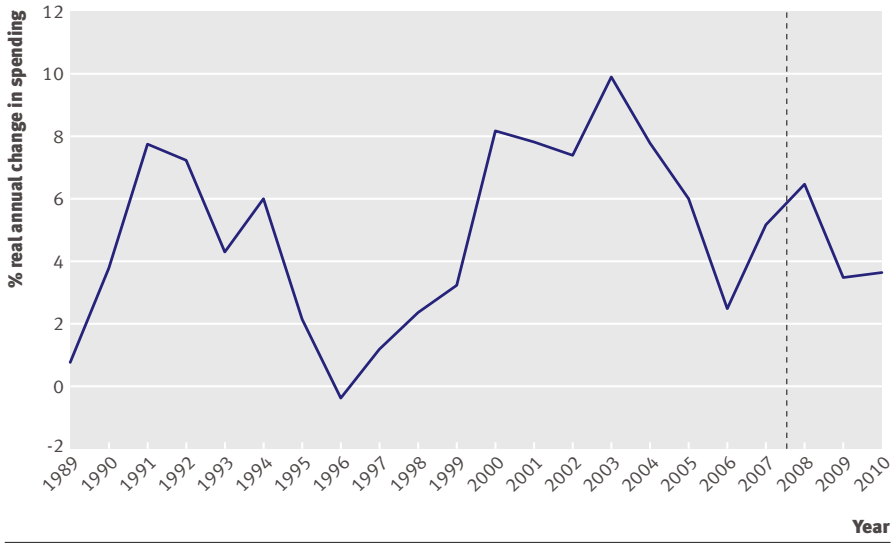

Fig 3 NHS real annual percentage spending.[16] Data for 2008-9 to 2010-11 are estimates based on 2007 spending review in England and draft plans for Scotland, Wales, and Northern Ireland

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