A note on the utility of austerity

Journal:	*Critical Public Health*
Manuscript ID	CCPH-2015-0129
Manuscript Type:	Editorial
Keywords:	Austerity, Public health, neoliberalism

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Austerity hangs like a global spectre over health and welfare spending and provision. It is the new orthodoxy, an accepted popular 'fact' that we are all living in an 'age of austerity' (Farnsworth and Irving, 2012). The global prevalence of austerity raises important questions about its ubiquity. Why is it everywhere? What is the utility of austerity?

Much of the debate and comment about austerity has focussed on what it actually is. In a previous editorial for this journal Labonté (2012) characterised the 'austerity agenda' as the fall out from the 2007 global financial crisis. He sought to answer where critical public health might go next in dealing with the consequences of this austerity agenda. In the UK the backdrop of an unprecedented deficit in the public purse has provided the rationale for fundamental reform of the National Health Service (NHS), amidst political rhetoric decrying the unsustainability of a publicly funded health service and the need for £20bn in savings to be hewn from the NHS budget (DH, 2010).

Drawing from Hendrikese and Sidaway, (2010) Labonté argued that austerity was a new extended form of neoliberalism, a so-called neoliberalism 3.0, where the benefits of previous iterations of neoliberalism are cashed in by an increasingly avaricious top 1% (the fact that the term 1% has an accepted meaning across countries and inside and outside the academy underscores the ubiquity of austerity). In a similar timeframe Dorling (2014) points to increasing levels of global inequality underpinned by growing income disparities, with the top 1 per cent increasingly taking higher shares of national income. In large part this is due to a fundamental shift in the politics of redistribution, whereby less tax revenue is collected from higher earners – in the UK context we see this in the form of £48 billion tax cuts between 2010-15, through measures such as increased levels of income tax personal allowance, and reductions in rates of corporation tax (Adam and Roantree, 2015). The neoliberal economic argument that underpins these changes is that the economic incentive effects of tax cuts will increase levels of economic activity and thereby create positive growth in the economy (Harvey, 2005). In this context, Reinhart and Rogoff (2010) made the economic case for pro-austerity policies in the USA in their notorious Growth in a Time of Debt paper, linking lower rates of economic growth with higher rates of public debt.

This austerity agenda creates a circular set of conditions whereby a prevailing austerity imperative positions economic growth as the only way of handling a public deficit, and economic growth is only possible through increased tax concessions. These tax concessions are only possible through a reduced public spend by government. So in order to control the deficit we need to reduce state spending. This statement is only true if we accept the austerity imperative. And so the cycle begins again.

One consequence of this tautology is that the provision and funding of health and social care are easily portrayed and discussed within a very instrumental economistic

logic. Health and social care are construed in terms of costs and benefits. The consequent precarity of health and welfare budgets allows for talk of conditional welfare payments (Clarke and Newman, 2012) or user charges for NHS treatment (Thomson, Foubister and Mossialos, 2010) to creep into public debate on the basis of a prerogative of economic scarcity.

It is this paradox that underpins government claims that publically funded health and welfare provision are no longer sustainable in the face of unprecedented levels of public debt (DH, 2010). Within this paradox the primary job of government becomes one of slashing the deficit; this austerity imperative comes to inform all public-spending decisions. Within this austerity imperative the emphasis is placed not on increasing state revenue (through new redistributive policies for example), but rather on reducing levels of state expenditure. But it is not, and cannot be simply a question of economics. Even if the economic arguments made sense (and bear in mind, as Herndon, Ash, and Pollin, (2014) demonstrate, Reinhart and Rostoff's 2010 arguments did not) the long-term effect of these sorts of reforms may very well cost far more economically, socially, politically and culturally than any short term economic gain.

In this sense, it is useful to consider these mechanisms and processes as part of an 'inequality machine' (Shrecker, this volume), intent on ratcheting up levels of inequality on a global scale, with effects that will not necessarily be apparent for a number of years. Shrecker argues that any reduction of health inequalities is predicated upon a concomitant reduction of economic inequalities. The processes involved in reducing these inequalities are not short-term solutions; rather they are long term intergenerational projects over a number of years. Schrecker concludes that tackling health inequalities and their underlying economic drivers may prove intractable unless we consider the effects of these inequalities outside of a simple cause and effect relation. In order to do this we need to tap into wider issues of social reproduction. For example, historically the NHS could be regarded as a triumph in addressing enduring health inequalities in the UK, with the state playing a central role, such that, year upon year, the UK state reproduced lower levels of health inequality, due to the success of the NHS as a free universal service based on need, not ability to pay. To tamper with this success story (such as requiring £20 billion in efficiency savings) creates the potential at least for some of these gains to be reversed. Downing and Harvie (2014) develop a line of argument that constructs events around the 2007-8 crisis as multi-faceted global crisis, lurching from a crisis of capital accumulation, through a crisis of social reproduction overlapping with a fiscal crisis of the state. According to Downing and Harvie, the state is withdrawing from the sphere of social reproduction; the need for hardline economic austerity allows them to do that without provoking a legitimacy crisis. In withdrawing, the state seeks to push the costs of social reproduction (health and social care) into the unwaged realms of the home and community, whilst simultaneously seeking ways for this 'terrain of social reproduction to be harnessed for profit', through an expansion of opportunities for voluntary sector and for-profit actors in associated health and social care fields. It is in this context that the neoliberal model of the state becomes apparent. The neoliberal project does not seek to eliminate the state, rather, as

Hendrikse and Sidaway (2010) argue, neoliberalism seeks to occupy the state, such that state and market become enmeshed. But it is not the levels of public debt that determine the viability or otherwise of the public services, rather it is the strategy that is chosen to tackle that debt that determines their viability.

On the one hand we have a series of economic crises that have created unparalleled levels of public debt. On the other hand, we have governments at national and international levels, arguing that we need faster, better, more efficient markets in order to fuel growth and reduce the debt, within an overall climate of reduced levels of direct taxation. In the midst of this we have a new orthodoxy predicated on an occupied neoliberal state, where market and state are enmeshed in contradictory projects of reduced public spending coupled to corporate profit making on the back of health and social care provision. What austerity does in all of this is provide the ideological cover for the processes of reform. Austerity presents these changes as driven by economic necessity. The real concern is the impact that this hollowing out of health and social care will have upon generations of people using these services. In this context it becomes increasingly difficult to see austerity as nothing more than an 'inequality machine'.

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