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The Cost of Austerity Policies for Public Health

AARON REEVES

People are living longer today than ever before, thanks to improvements in life expectancy achieved over the past 100 years. Until recently, this trend looked like it was going to continue. Since 2011, however, something seems to have changed: advances in life expectancy have slowed considerably in many high-income countries. Over the past six years, gains in the United States, Britain, the Netherlands, Germany, and Sweden were less than half what they were in the six years before that. In the United States and Britain, life expectancy has barely risen at all—approximately one week per year on average over the past six years. In 2015, life expectancy at birth actually fell in the United States, Britain, Italy, Spain, and Germany, among others. Since then it has continued to fall among some marginalized groups, even in countries where life expectancy on average remained stagnant or continued to rise.

Declines in life expectancy are rare but they have happened before, usually following state collapse or acute epidemics. After the fall of communism, average life expectancy in Russia declined by nearly five years between 1991 and 1994. Similar declines, albeit not as extreme, occurred in other former Soviet states over the same period. Life expectancy also fell in the United States in 1993 due to the rise of HIV/AIDS. But the stalling of life expectancy in recent years does not look like either of those crises.

While the countries with the largest slowdowns, the United States and Britain, are certainly in the middle of a period of political uncertainty, they are hardly in the process of state failure. Likewise, a few widespread flu outbreaks in high-income countries are not comparable to the HIV crisis of

the early 1990s. Nor is the slowdown occurring because some countries are reaching the upper limit of the human life span: in other rich countries where people already live longer, life expectancies have continued to increase at roughly the same rate. Some other explanation is required to explain this worrisome divergence.

One obvious explanation is the global financial crisis and the imposition of austerity measures (reductions in public spending, especially on social programs) in many of these same countries. And yet at the start of the crisis, it was not unreasonable to assume that the ensuing recession would actually improve health, reduce mortality rates among some groups, and accelerate gains in life expectancy. It may sound counterintuitive, but evidence from earlier recessions seemed to point toward that outcome.

When finances are constrained, people may cut back on smoking or consume less alcohol, drive less, and eat fewer high-calorie or high-fat foods. Workers may also work fewer hours, exposing themselves to fewer occupational hazards and pollutants. Even greater unemployment may have positive health consequences, relieving people of the stress of intense working conditions and giving them more time for exercise and other health-enhancing activities. In past recessions, it seemed that these benefits were so widespread that the overall health of the population improved, despite the stress created by greater economic uncertainty.

The Great Recession, however, was different. Not only was it far deeper and in some places more prolonged than earlier crises, but it was also compounded by a set of fiscal policies that attempted to reduce government debt through cuts in spending and, to a lesser extent, tax increases. Far from accelerating the recovery, austerity only deepened the crisis, increasing unemployment and poverty

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beyond that which had been created by the collapse of financial institutions alone. Together, these economic trends increased depression and suicide rates, and left many unable to afford food and medical care.

FALLOUT IN GREECE

Greece has become the awful distillation of everything wrong with austerity. In 2010, Greece's ballooning budget deficit triggered a sovereign debt crisis that threatened to spread across Europe. The "Troika" consisting of the International Monetary Fund, the European Central Bank, and the European Commission agreed to provide a bailout package to the country. The loan came with conditions that required the government to embark on a program of drastic spending cuts. It was not long before the harms to health began to emerge.

Sharp rises in HIV infections among injecting drug users occurred at the same time as shortages in basic medical supplies, such as sterilized needles and latex gloves. When Greece tried to renegotiate drug prices in an effort to reduce spending, some pharmaceutical companies refused to supply their products. Unmet medical needs rose dramatically, particularly among the poorest groups.

In 2016, the European Center for Disease Prevention and Control warned that 10 percent of patients in Greek hospitals were at risk of developing potentially fatal infections. Infant mortality rose over the same period (from 2.7 deaths per 1,000 live births in 2008 to 4.2 in 2016), due to problems in perinatal care and reduced access to essential health services. The proportion of infants with low birthweight grew as well.

The Greek bailout program has now formally ended, but the financial difficulties and associated health consequences show little sign of easing. Greece may be exceptional, but it is not alone. Similar trends, albeit on a smaller scale, have occurred in other European countries that followed a similar policy path.

Just like in Greece, suicides rose in many countries when people began to lose jobs during the Great Recession. According to one estimate, there were 10,000 excess (that is, more than would have been expected based on previous trends) economic suicides in Europe and North America between 2008 and 2010. It is crucial to note that this esti-

mate captures the impact of the recession alone. It does not account for the impact of austerity, which had not started yet, and which would go on to both create additional unemployment and undermine institutions and policies that mitigate the effects of joblessness. Cuts to those services only compounded an already dire situation. Economic suicides are less common in countries offering more generous unemployment benefits. Elevated suicide rates may be part of the reason life expectancies have not grown as quickly since 2011.

BRITISH WELFARE REFORM

Reducing social-protection spending through welfare reform was a central feature of austerity. Many governments cut social security payments or made it more difficult to claim benefits. Such reforms are, of course, not new. The United States made a number of similar changes in the 1990s. But in the period following the financial crisis, Britain stands out because of the speed with which it pursued a radical restructuring of its welfare-

state institutions. Many of the changes have exposed people to precarious economic circumstances and harmed health. The case of Britain is especially enlightening because its recession was not as deep and its debts were not as

high as they were in other crisis-affected countries that did not pursue austerity policies.

One of Britain's earliest welfare reforms was reducing the amount of financial support offered to people on low incomes to help them pay their rent. This cut, which took effect in 2011, was intended to save 1.6 billion pounds (\$2.1 billion) but came at the expense of pushing tens of thousands of households into poverty. It also harmed health, increasing the prevalence of common mental illnesses, such as anxiety and depression, by 1.8 percent, meaning that around 26,000 additional people experienced new depressive symptoms following this policy change.

Over the same period, the government rolled out a new work-capability assessment for people receiving financial support for long-term health conditions. This made claiming benefits far more stressful and led to reductions in payments for those deemed able to work. Not only has this largely failed to help people return to work, but it has also been linked to increases in prescriptions for antidepressants and in suicide numbers.

Cuts are weakening the capacity of health systems to respond to preventable illness.

Alongside these reforms, the criteria for entitlement to out-of-work benefits have been made more stringent at the same time that the consequences of failing to meet those conditions have become more severe. If the unemployed fail to meet just one of these criteria they may be sanctioned, which now cuts off financial support from the state for at least one month (but possibly up to three years). Sanctions increased dramatically between 2011 and 2014, leaving many without the resources necessary to make ends meet.

Many people have been showing up at food banks just to meet basic needs, but food banks are not universally available and not always well stocked. In places where they are unavailable, many families have simply gone hungry. While the number of aid recipients being sanctioned has fallen in the past few years, this does not mean fewer people are food insecure—that is, coping with inadequate access to food due to financial constraints. Food bank usage remains high (and is growing) because the impact of temporary cuts in social security can cascade into other areas of life, pushing people into prolonged periods of deprivation. The lesson from the unemployment benefit reforms is clear: short-term policy changes can have long-term effects on the health and well-being of the population.

Advocates for making the conditions on entitlement to benefits more stringent—and the penalties for failing to meet them more severe—claim that tougher rules increase the labor supply by motivating people to find jobs. Such measures, they argue, will reduce government spending and boost economic growth. The problem, however, is that these reforms have not worked as predicted. There is little evidence that they have helped people find work, and in fact there is evidence that they may have pushed some groups, such as people living with disabilities, even farther away from the labor market.

On top of this, sanctions seem to systematically fall more heavily on certain groups. Single parents and the disabled are particularly likely to be sanctioned. Evidence of this led a parliamentary committee to conclude in 2015 that intensified conditionality had led to “some vulnerable individuals . . . being ‘set up to fail.’” Austerity policies thus have disproportionately harmed already disadvantaged groups, leaving them destitute without delivering the expected improvements in their economic circumstances. The health effects of these changes are still being felt, as people who

have been sanctioned struggle to get their lives back on an even keel.

Rising hunger and greater poverty are obviously tragic in their own right, but some might argue it would be naive to assume they will immediately affect life expectancy, especially if the economic shocks are limited in duration. A period of food insecurity, for example, may be bad for mental health but it does not necessarily imply malnutrition or having a baby with low birthweight in the short term, and therefore probably will not affect mortality rates. While this is undoubtedly true, it overlooks the harder edge of welfare reform. Many of the changes to social security have not only led to more people falling into poverty, but have also increased the depth and duration of poverty.

One manifestation of the rise in destitution in recent years is the growing number of homeless people. Homelessness had been declining in Britain since the turn of the century, even during the recession. However, in 2010 the number of homeless people began to rise, a trend that has continued and seems to be partially explained by reductions in spending on housing services and emergency housing assistance. Homelessness is a major public health concern because it is associated with an elevated risk of infectious disease, physical harm, and premature mortality, all of which negatively affect life expectancies, now and in the future.

Unfortunately, these problems do not seem to be going away. Child poverty continues to rise because poverty among people with jobs is also higher and the rollout of Universal Credit—a new form of social security intended to replace and combine many of the older systems—is likely to make things worse. It applies sanctions not only to the unemployed and those experiencing long-term illness but also to people who have jobs but receive some financial support from the government, such as working tax credits. Universal Credit will eventually affect the families of around 7 million claimants. As former Prime Minister John Major commented, the new system may be “theoretically impeccable” but it is “socially unfair and unforgiving.”

PINCHED PENSIONS

British austerity measures tended to focus on people of working age, leaving pensioners in a better position relative to others than ever. A series of reforms ensured cost-of-living increases in the state pension. But the elderly were not protected in every country. Due to population aging, pensions have become one of the largest single areas of public ex-

penditure in high-income countries. Governments around Europe used the economic crisis to reconfigure pension schemes in order to cut spending.

Shortly after austerity began to spread, the Organization for Economic Cooperation and Development expressed concern that proposed cuts to pensions would harm the financial security of the elderly. Many countries went ahead anyway: the Czech Republic and Norway altered inflation indexing rules to reduce spending over the long term, while Greece and Hungary took a more immediate approach, implementing fairly stark reductions in payments.

The effects of these reductions in European state pensions have not been benign. They have widened inequalities in access to care and led to increases in unmet medical needs among the elderly, particularly for those who were already at the bottom of the income distribution. This may partially explain the excessive fatalities linked to recent flu epidemics that have ravaged elderly populations across the continent.

'DEATHS OF DESPAIR'

There is a crucial difference between Europe's experience and that of the United States in the decade since the global financial crisis. Stalling life expectancy in Europe is closely linked with higher mortality among the elderly; in the United States, rising mortality rates have been most striking among people of working age. Unsurprisingly, the causes of these excess deaths have been quite different too—mainly suicides and drug overdoses in the United States. Many of these deaths are clearly not the product of the Great Recession alone, nor of any systematic state retrenchment in response to the financial crisis. But austerity nonetheless could also be at work in driving what the economists Anne Case and Angus Deaton of Princeton University have called “deaths of despair.”

European governments are, in many instances, merely emulating welfare reforms already implemented in the United States in the 1990s, which also reduced the generosity of benefits and toughened conditions. At the same time, European countries such as Britain and Germany are now witnessing stagnating wages, something Americans have lived with for almost 30 years.

By exporting austerity policies that keep wages low and earnings insecure, particularly for those

with less education, the United States could also be exporting the conditions that have created “deaths of despair.” Europe may never reach the levels of such deaths seen in the United States due to differences in the political economy of European health-care systems: the limited presence of private insurance has constrained the incentive for prescribing painkillers, which are the only treatment available on many private plans because they are cheaper. But the United States may provide a grim forecast of what future European crises could look like if more countries follow its lead and allow a steady deterioration in economic security and the social safety net, especially for people with limited education.

CARE CRUNCH

Beyond welfare reform, austerity has also affected health care systems. The pressure placed on their budgets during the global financial crisis prompted many European governments to seek savings by streamlining bureaucracies or renegotiating contracts with service providers. Some countries also introduced co-payments for prescriptions and other outpatient services, adopting a more US-style model. Meanwhile, the United States went in the opposite direction. Rising unemployment rates exposed the precariousness of a health insurance system tied to the labor market and created the political will during President Barack Obama's first term to expand coverage through passage of the Affordable Care Act, although not all states exploited its full powers to extend coverage.

Britain's National Health Service (NHS) is an intriguing case because it has not straightforwardly followed either path. It neither increased co-payments nor expanded services. Instead, spending on health was “ring-fenced” by the Conservative-led coalition government (that is, protected from cuts)—and this was in the context of major reductions in spending almost everywhere else. Yet this policy created the most sustained decline ever in NHS spending as a percentage of gross domestic product because demand for services and costs are both rising while the amount available to spend has remained relatively flat, resulting in the most financially difficult decade for the NHS since its inception in 1948. The American political scientist Jacob Hacker describes such dynamics as “policy drift”: the main-

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tenance of the status quo prevents adaptation to shifting social conditions and changing risks.

Over the past few winters, the NHS has increasingly struggled to cope with the demands placed on it, especially during intense flu epidemics. The winter of 2017–18 was particularly difficult. Some local health-care providers canceled all nonessential surgical procedures. Subsequently, the mortality rate in the first quarter of 2018 was the highest since 2009.

Elderly people are one of the groups most reliant on effective health and social-care services, such as home support for people too frail to care for themselves. When these services break down, the elderly will suffer, and the data suggest that some of the most vulnerable—the oldest of the old—have indeed been left exposed. The real-terms reductions in public expenditure on social care (that is, the failure of spending to keep up with demand or inflation) under austerity policies were associated with higher mortality rates among the elderly, especially those in care homes—precisely the groups that seem to be driving the slowdown in life expectancy gains in Britain. During the 2015 general election campaign, the government announced a muddled plan to address the deficit in social-care spending and missed an opportunity to resolve this crisis, leaving many elderly people with inadequate care and, all too often, shorter lives.

Sadly, Britain is not alone. Between 2014 and 2015, 12 out of 18 high-income countries witnessed declining life expectancies among women, and 11 also had declines among men. In many instances, falling life expectancies were observed among people over the age of 65. The most proximal cause of this spike, according to the demographers Jessica Ho and Arun Hendi, was an especially acute flu epidemic.

This raises another, more structural question: how can a flu epidemic have such dramatic consequences in some of the richest countries with the most modern health care systems on Earth? The mortality spike illuminates more fundamental problems in some of these health-care systems. The real-terms cuts to health and social-care spending across Europe are weakening the capacity of health systems to respond to preventable illness among vulnerable populations.

SLOW TRAIN

Austerity has not affected everyone equally. Disadvantaged groups in the poorest areas are bearing

the heaviest burden. In the past few years, there have been signs that austerity is not only affecting health, but also widening health inequalities. Infant mortality, for example, increased in Britain for the first time in a decade in 2015. More striking is the fact that infant mortality has been increasing for the poorest children since 2010, leading to wider inequalities over time. These inequalities by class may well be rooted in the impact of the recession and subsequent austerity measures, which are now starting to affect families across the income distribution because of an overstretched health service.

The economic consequences of the Great Recession and the political choices made in response to the financial crisis are clear. Across the globe, tens of millions experienced greater material deprivation, millions became unemployed, and hundreds of thousands lost their homes. The implications for health still need to be unpacked. We have seen a clear slowdown in what had been a steady increase in life expectancy in some high-income countries. But increases in mortality among some groups are clearly not solely attributable to the global financial crisis, nor to austerity policies. Nonetheless, austerity has certainly harmed health even if it does not explain all of the decline in life expectancy in every country.

Austerity is a “slow train coming”: an unfolding crisis that is only now becoming visible in the published data. The true impact of austerity goes well beyond the most immediate health consequences: it increases material deprivation through cuts to social protection and other social services, including health systems. Poverty has a scarring effect on health, but the implications may not manifest themselves in the same year as the fall in living standards or even in the year after. It may take some time for this effect to show up as higher rates of mortality. In part, this is because many countries have not yet implemented, or completed, austerity measures that they announced a few years ago. The restructuring of welfare states in response to the economic crisis is an ongoing process.

For many, it is too late to prevent the harms of austerity—but this does not mean there is nothing to be done. To the extent that austerity is still being rolled out, it can be stopped. Where it has already been implemented, it can be reversed. Austerity was always a political choice, an experiment conducted on the people of Europe and elsewhere. Reversing austerity is a choice too, one that will likely save lives. ■