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Summary Paper

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Does austerity harm health?

Summary
In this seminar, Dr Aaron Reeves addresses three questions:
1. What changes have there been to health and social protection spending across Europe?
2. Has the economic crisis harmed health?
3. What lessons can be drawn from this recession on how to protect health systems and also people's health.

Dr Reeves concludes that his reading of the data is that health and social protection austerity have harmed health, and at the same time have harmed the economy. In particular, it seems to have harmed the most vulnerable to the greatest extent. Finally, it appears that austerity is a choice. Drawing on the work of his two of his colleagues, David Stuckler and Sanju Basu, he proposes an alternative way forward that focuses on providing social protection for the most vulnerable, helping people return to work and investing in health. Dr Reeves' hope is that the work that has been done in this area by a number of scholars will start to have an impact on the debate around how recessions are dealt with in the future. We must start to think carefully about some of the decisions that are being made and take into account the potential health effects of these types of policies.

Introduction

This seminar focuses primarily on issues concerning the economic crisis, austerity and health. It is centred around the relationship between political, economic and social factors and the ways these impact and impinge on the lives and health of populations.

Two stories provide a context for this work. The first is a tragic event that took place in Greece at the end of last year. A young 13 year old girl died from inhaling fumes from a makeshift oven. Her mother couldn't afford to pay the electricity so had made this stove to cook on and to heat the home. The second concerns a couple in Italy, Romeo and his wife Anne-Marie. Romeo was unemployed and unable to find work. As part of the Italian government's austerity measures, the age at which Romeo could claim his pension was extended. Faced with the prospect of living on just Anne-Marie's pension, the couple decided to take their own lives. These stories highlight that there are real people behind the big data and numbers: it is critical to remember that there are lives at stake when talking about these issues.

These stories also contrast with a third event: a recent speech by David Cameron at the Lord Mayor's House. In this speech, Mr Cameron talked about a new economic reality. He advocated a form of permanent austerity saying that it was not going to be possible to return to the situation we have had under previous governments. From Dr Reeves' point of view, what is missing from this debate is a discussion of the health effects of austerity and the financial crisis. The question that Dr Reeves and his colleagues are trying to answer is whether, alongside these anecdotes, there is other evidence of the harm of austerity?

Part 1: Patterns of austerity and stimulus

Dr Reeves started by showing a series of 'heat maps' (see slides). These map patterns of spending by different countries in different domains (health, defence, education and so on) and are a useful way of representing some of the changes that have taken place. Broadly speaking, this map demonstrates that countries have made varied decisions about where they have decided to implement austerity and where they have decided to invest additional funds and increase expenditure. In the health domain, the map shows that a number of countries reduced spending by substantial amounts in the period 2009-11.

For example, we know there have been radical changes in Greece over this period. In particular, they tried to reduce healthcare spending by doing three things: Reducing public spending on drugs; Decreasing the size of the workforce; Changes to purchasing of health services. One implication is that the amount of spending on needle exchange programmes was reduced. The team have observed that this is associated with a rise in the number of people with HIV and AIDS specifically among injecting drug users. Another observation is that there has been a 50% increase in the number of people who say 'yes' when asked the question 'do you have an unmet medical need?'. This is higher among the elderly and, somewhat surprisingly, is nearly double in urban areas. People are not getting the care they need because they can't afford it, it is too far away and they need to contribute to payments for pharmaceuticals.

Social protection is another area where governments have made different decisions. Social protection includes social welfare, unemployment benefits, housing benefits, pensions and so on. It is the traditional government-sponsored programmes where support is provided for some of the most vulnerable people in society. There is a great deal of variation in patterns of spending across countries. A particularly interesting concept at play here is something known in economics as the 'automatic stabiliser. During a recession, more people require more help from the state, and social protection spending would be expected to increase across the board. So in the countries where there is a reduction in spending this is indicating a quite drastic change compared to the rise that would be expected.

Looking in detail at the different types of social protection spending, broadly across Europe, the greatest reduction is in spending on sickness and disability followed by low income families and then unemployment. So some of the most vulnerable people, in societies across Europe (including the UK), are feeling the brunt of these types of austerity measures. So again what are the implications? What does this mean for people?

The trend for severe material deprivation in the UK (see slide 18) shows a rise during 2009/10 (during the recession), flattens in 2010/11 and then shows a steep rise in 2011/12 (austerity measures introduced). There are similar trends in the number of people unable to keep their houses warm and people unable to make ends meet. These trends are particularly concerning because there is good evidence that these things affect long-term health.

In England, the data shows that the greatest reduction to local authority budgets per head of population has occurred in areas that are already the most deprived and that experience the most inequalities. This seems counterintuitive – aren't these the areas we should be protecting? Similarly if we compare cuts in Local Authority

budgets with unemployment there is a correlation: the larger the cuts the greater the increase in unemployment. Again looking at homelessness even during the recession the number of homeless people, as identified by Local Authorities, was decreasing. However, since the introduction of austerity measures the number of homeless people has increased.

There have also been recent changes in the way disability and incapacity benefits services are delivered. The government's own impact assessments show that over a quarter of a million people will experience reduced payments of up to £4,000/year. Of these, 150,000 are currently living in poverty and the changes will push an extra 50,000 into poverty across the UK. These are substantial changes and substantial sums of money that will have a direct impact on the people who already have the poorest health.

Scotland is no exception. A recent report on welfare reform has shown that the most deprived regions have also received the largest cuts. Glasgow has seen a decrease of £650 per year per working adult. In terms of incapacity benefit, it is estimated that 144,000 people in Scotland will be affected and they will each experience decreases of around £3,000 a year. Cuts in tax credits will affect 372,000 people by a decrease of around £810 per year, and 80,000 people will be affected by housing benefit changes with a decrease of around £1,010 per person (excluding the spare room subsidy, also known as the 'bedroom tax').

These figures and trends are all concerning. There is good evidence for the effects of poverty on health and the way it exacerbates health inequalities. So these changes are only going to make worse the situations faced by some of the most vulnerable people in our societies.

Part 2: Has the economic crisis harmed health?

But specifically what has the recession done in terms of health? Most of the data shown so far is looking at what we know already. The evidence on the direct impact of some of these policies is not so strong because the data is not necessarily available yet. From Dr Reeves' point of view it is a 'scandal of ignorance' that we can have up-to-the-minute economic data but health data sometimes takes years to access. The team is still waiting to assess the impact of what has happened, but some things are known.

Looking at previous recessions across Europe, the economic data shows that there are mass rises in unemployment and that alcohol abuse also tends to rise. Interestingly, data for this recession indicates that the average consumption has declined slightly. However when this is broken down it shows two distinct groups: The first, people whose alcohol consumption declined but then has risen steadily again; and the second, people who were heavy drinkers before the recession whose consumption increased even more. So it is not enough to look at overall broad trends we need to focus on those who are most at risk of alcohol abuse and the impact of the recession on these people.

The recession also has an impact on the suicide rate. In periods where unemployment increases rapidly, the number of suicides tends to go up, and is also seen to rise most in people of working age. Data for the most recent period available shows the unemployment and suicide rates rising across Europe. This association has been well documented over several decades. However the team are interested

in whether this association is inevitable? Previous research has shown that active labour market programmes (ALPs) may be one mitigating factor. These are schemes that provide support to people who are at risk of becoming unemployed or who are unemployed. Looking at these programmes across Europe there is a clear association. In countries with a high investment in ALPs the suicide rate has risen slightly and then declined. In countries with a low investment in ALPs, the suicide rate has risen quite rapidly during this period.

So this is some of the available evidence on the impact of the recession on health but there are also some lessons for the future.

Part 3: Lessons for the future

Looking at some of the high-level themes and big debates, what can social scientists say about these issues?

The first is the question: '**Why have some countries cut their healthcare budgets?'** There are a number of different possible explanations.

- The first is the debt crisis. The suggestion is that countries were worried (often due to recommendations of the International Monetary Fund (IMF) and the European Commission that their debt was too high and this was damaging their economies and needed to be reduced. However the study that is often quoted to back up this argument was shown to be incorrect. A recent IMF paper also shows that this is untrue.
- A second explanation is political ideology. Some people have said that parties to the right are more likely to make these kinds of reductions than parties to the left.
- There is also a 'depth of the recession' argument: the hypothesis that this recession was so deep and so broad that it was necessary to implement this type of reduction in spending on healthcare and other services.
- At the same time some people have argued that it is very difficult to reduce healthcare spend because of its 'visibility'. It is a large part of the budget and is an area that people feel strongly about and therefore it is difficult to cut.
- A final explanation is the role of international financial institutions such as the IMF.

An important concept in understanding these arguments is the 'fiscal multiplier'. The fiscal multiplier attempts to estimate the impact of changes in government spending on the economy. If the fiscal multiplier is greater than 1 there is increased growth in Gross Domestic Product (GDP). If the multiplier is less than 1 there is slow or even reduced growth. When the recession was starting to get underway, the IMF published a paper that estimated that the fiscal multiplier was about 0.5. This was important as, in line with recommendations from the European Central Bank and the European Commission, governments were saying that reducing spending would help economic growth. However in 2011 the IMF said that they had underestimated the fiscal multiplier and that the actual multiplier was 1.7. This means that investing in maintaining government spending would have assisted the economic recovery and that taking money out actually did economies more harm.

Understanding this big picture, that investing in spending is on the whole good for the economy, the team at Oxford have also looked at different sectors of government spending. As a general rule countries that kept their spending high have recovered faster. Looking at healthcare expenditure in detail across different

countries they found that there is a lot of variation. This raises a question: is reduction in health spending a choice? In spite of the depth of the recession, governments appear to have some choice about the decisions they make.

The team went on to analyse data from 1995-2011, looking at government changes in health spending over this period. They found a number of things that did not explain the difference in health spend:

- The change in GDP, in other words the depth of the recession.
- The level of public debt. Some countries with very high levels of public debt still invested in health and some with very low levels of public debt (for example, the UK) chose to reduce healthcare spending.
- Political ideology. The results suggest that the ideology of the governing party whether it is left or right-leaning does not seem to be driving the different choices.

So what is driving the decision to reduce healthcare spending in some countries? The team identified two key factors. One is the role of international financial institutions and the other is a decision to reduce total government spending. If there was no involvement from the IMF or other international financial institutions, then the data shows that the probability of decreasing health spend, if there is no overall austerity, is around 15-20%, which is quite low. However if there is overall austerity in a country then the probability of there also being a decrease in healthcare spending goes up to around 45%. In countries like Greece, that has both IMF involvement and overall austerity reductions, then the probability of reductions in healthcare spending is very high at around 80-90%. This raises interesting questions about the policy decisions being made and the impact these are having and what this might mean for future recessions.

A second key area which may have some lessons for the future is **the debate around the fiscal multiplier**. Dr Reeves and his colleague calculated the actual effect to be 1.6 which is very similar to the amended IMF figure. So in simplified terms, for every £1 invested the economy would get approximately £1.60 back.

However, if governments invest in health, the multiplier is much larger at around 4. In education the figure is larger again at around 8, and for social protection investment it is around 2.8. So these results say two things. Not only did the IMF make a mistake in their guidance to suggest that countries should implement austerity but more than that, the way some countries have gone about austerity by reducing spending on health and social protection, has actually harmed the economy at the same time that it harmed the people it was meant to protect.

Of particular interest, data from the British Social Attitudes Survey 1983-2011 shows that the number of people who want to reduce taxes and spend less on social benefits, health and education never goes above 10%, and broadly speaking, a majority of people want to either keep this spending the same or increase it. There has never been a broad base of public support for decreasing spending in these areas.

A final issue Dr Reeves covers in the seminar is that of **denial**. This is the experience of people with specific vested interests refusing to accept the weight of the data that is before them. This denial he suggests has two features. The first is

the way the data is used with specific items being 'cherry picked'.
The second feature is setting up impossible expectations for the evidence that will be convincing, while at the same time refusing to fund studies that would provide this evidence. This trend is something the team have seen from some quarters across Europe. One of the implications for the future is to think very carefully about how we deal with these issues. How do we convince people that there are very real consequences to these choices?

Conclusion

Dr Reeves concluded by saying that his reading of the data is that health and social protection austerity have harmed health. In particular it seems to have harmed the most vulnerable to the greatest extent. The full extent of this harm may not become clear for a few years as further data become available over time. Finally, it seems that austerity is a choice. It is a choice that is made for a variety of different reasons. It is one that is politically motivated to a great extent and often has the backing of certain powerful international financial institutions. In addition, in his opinion, there is good evidence that it has harmed the economic recovery.

So what is the alternative? Two of his colleagues, David Stuckler and Sanju Basu, have called for a 'New, New Deal' for Europe. They have stated that if austerity was a randomised controlled trial it would have been stopped a long time ago because of the negative impact it has had on the people who have been exposed to it in Europe. In the face of current and future recessions this 'New, New Deal' would be characterised by three elements:

- First, do no harm. We need to provide social protection for the most vulnerable people in our societies because if we don't they will be exposed to and bare the brunt of these economic variations.
- Help people to return to work. We need to invest in supporting employment in our communities and one way is by governments investing in assisted work programmes.
- Invest in the health of the public. We need to provide healthcare for people. Taking away much-needed services will only expose the most vulnerable to the effects of the economic crisis.

So returning to the three stories at the beginning of this presentation, Dr Reeves' hope is that the work that has been done in this area by a number of scholars will start to have an impact on the debates around how recessions are dealt with in the future. We must start to think carefully about some of the decisions that are being made and take into account the potential health effects of these types of policies. Rhetorically the question that could be asked is: will we continue to balance budgets on the backs of the poor?