

How Austerity is Worsening Coronavirus

By Matthew Soener

The Covid-19 virus follows years of austerity politics in Europe and this market-driven ideology is already shaping discussions of how we should handle it. This article examines the way these decisions have affected our ability to respond to the current epidemic.

The Covid-19 virus has exposed the frailty of our political and economic institutions. While the precise origins are still being studied, we know our economic system increases the likelihood of animal to human transmission of pathogens like coronavirus through industrial agriculture, deforestation, urbanization, and biodiversity loss. Now governments are tasked with rapidly responding to the crisis which has included everything from massive asset repurchases to the supply of crucial medical equipment. The virus poses big questions about the form global capitalism will take from this time on.

The severity of the crisis and the scale of political responses have prompted some to call for progressive reforms. For example, high ranking Labour member, John McDonnell, writes in *the Guardian* "if we are to build the resilience to cope with any further waves of this virus, or other future unknown threats, our society needs to be built on fully funded, publicly owned and democratically controlled public services."

However, this future is hardly guaranteed. Despite *the Atlantic's* claim that "there are no libertarians in an epidemic," the virus and economic crisis have not changed the minds of market fundamentalists. The *Wall Street Journal* has gone so far as to proclaim that the "coronavirus vindicates capitalism" and anticipates markets will adequately respond to the economic and health crisis.

Covid-19 has brought to the fore economic ways of thinking. It has become common, especially in the Anglo world, to debate tradeoffs between economic growth and human health. This kind of neoliberal mentality will figure prominently in the months and years to come. We should therefore look more carefully at how policies like budget cuts and basic political economy have affected our ability to respond to the crisis. In this essay, I survey European countries' healthcare capacity for dealing with the epidemic in the wake of austerity.

From Austerity to Epidemic

European welfare states were constructed with the idea that social protections could accompany economic growth. Since the 1970s, however, this social democratic ideal has eroded. Many have been convinced that social protections stand in the way of economic growth. The idea is that politicians should balance budgets and cut social services like healthcare so there will be enough future growth for the market to deliver on those provisions.

This way of thinking has become absolutely dominant in the Western world. It has shaped not only the last several decades, but especially how we dealt with the last economic crisis in 2007-8. The economic turmoil caused public debt to increase markedly and there was pressure to cut spending in order to restore growth. Austerity was particularly strong in Europe. Since European countries have been badly affected by Covid-19, the continent serves as an interesting case to link austerity with healthcare capacity.

Social institutions like healthcare are constrained by capitalist growth dynamics and politics. Europe had implemented numerous rules prior to the sovereign debt crisis which automatically enforced budget tightening. For example, the Stability and Growth Pact limits deficits to no more than 3% of GDP. When the economic crisis came, this made it extremely difficult to respond through traditional means like

running large deficits in order to invest. There were additional constraints imposed on those 19 European Union (EU) member states who belong to the single-currency block, the euro. By sharing a currency, governments relinquish fiscal autonomy and the ability to revalue their currency. Instead, eurozone states had to devalue labor costs and cut social expenditures to restore competitiveness. The worst hit countries included peripheral members like Greece, Italy, Spain, and Portugal.

The healthcare sector was a casualty of this experience. A World Health Organization (WHO) study in 2015 noted that European countries had cut health budgets and a majority of countries reduced investment in hospitals as a direct result of the crisis. An estimated 1.5 million Europeans at minimum suffered unmet medical needs because of budget cuts. However, this has varied across the continent. According to the WHO, the share of per-capita healthcare spending has declined by 1.3% and 1.5% in Italy and Spain respectively between 2010 and 2017. Compare this with Switzerland where healthcare spending increased 15% or Norway where it increased 17% over this same period.

These differences shape how equipped countries are for dealing with the epidemic. Spending on every healthcare component has fallen in most European countries including medical goods, inpatient care, pharmaceuticals, preventative and long-term care. Admittedly, some of these components are not directly related to fighting the virus. Others are, however, including the conditions of medical staff as well as investment in hospitals such as beds and emergency equipment. These kinds of resources were targeted and cut after the crisis. A 2016 report on European healthcare by the Organization for Economic Cooperation and Development (OECD), a club of high-income states, concluded that “reducing wages in public hospitals, postponing staff replacement and delaying investment in hospital infrastructure were among the most frequent measures taken in EU countries to balance health budgets.”

One particularly important resource this might include is acute care beds. These beds serve a variety of functions including treating illness and injury, surgery, intensive care, and protecting patients from complications. In the age of coronavirus, these beds can be a vital resource. However, according to OECD data, the number of these beds per 1,000 people has fallen in every European country for which there is data over time (with the exception of the Netherlands) Between 2010 and 2017, the number of per capita acute care beds fell by 2.5% in Spain, 8% in Belgium, 11% in France, and 14% in Italy. Interestingly, some of the sharpest drop offs were in Nordic states which are known for their more welfare spending. Sweden has the lowest per

capita number of acute care beds in the EU. This, in tandem with the country's lax and unorthodox social distancing policy, might account for their relatively high number of per-capita deaths there.

Of course, the Covid-19 virus was a shock to governments and healthcare workers. But what makes this problem more distressing is that there were warning signs. After the H1N1 flu in 2009, for example, health bodies and academics recommended intensive care beds and stockpiling of essential medical equipment in Europe. There were numerous evaluations and policy responses but they varied. Judging by the declines in things such as acute care beds and hospital investment, we might surmise that some of these recommendations went unheeded.

Another simple way to gauge this is looking at the share of investments in epidemiological surveillance and disease control programs. These programs include resources needed for early detection, information sharing, preventative programs, and rapid intervention tactics. Again, there is variation in spending changes for these programs with Switzerland and Denmark increasing spending since the H1N1 outbreak. However, more countries have cut funding for these programs as a share of total health spending since 2010. This includes Belgium (-14%), Greece (-17%), Germany (-32%), and Sweden (-36%).

Doing More with Less

The picture that emerges here is straightforward. In times of crisis, the resources available in a healthcare system can be the difference between life or death. How much money coming in and how resources are distributed are political questions. Germany, for instance, has fared comparatively better than most of its neighbors because they have four times as many intensive care unit beds, ramped up testing, and ordered 10,000 extra ventilators from manufacturers.

Not everyone has German institutional capacity or resources. This is due in no small part from budget cuts. Austerity in Italy, for example, had numerous adverse health consequences even before the pandemic. As early as the 1990s, privatization efforts in Italian healthcare had resulted in inadequate care. Despite these facts, the Italian experience has still been used as a cautionary tale against publicly run health institutions for those already predisposed against it. Writing in the *Wall Street Journal*,

Joseph Sternberg correctly notes that investment problems in the Italian healthcare system in essential equipment like acute-care beds have worsened the crisis. However, instead of seeing the problem from fiscal spending limits and draconian debt-relief packages, he contends Italian healthcare is overly dependent upon central government spending and planning. Fault, in his view, lies with top-down government initiatives.

It is true that the Italian system is overwhelmingly tax-based and therefore linked to government spending. In a historical context though, the larger question is not the source of the financing but the flow. Italy saw a bigger GDP decline than any other EU state from 2008-9 and the budget tightening that followed didn't help. Health spending and other welfare measures were constructed in the context of robust mid-20th century growth. The secular slowdown of capitalist growth in the global north now puts those institutions under strain.

The more proximate problem, however, is not too much centralized planning in Italy but not enough of it. There have been interesting comparisons made between two neighboring and socio-economically similar Italian regions: Lombardy and Veneto. Despite their similarities, deaths have been vastly higher in Lombardy. Authorities in Veneto were much more proactive in testing, tracing positive cases, closely monitoring those who had been in contact with those testing positive, and protecting essential workers who are more exposed. Decentralization of the Italian healthcare system has led to these incongruities between regions and, for this reason, public health experts are calling for stronger national coordination.

Spain, like Italy, is also a hard-hit country that has suffered terribly from austerity measures. Spanish health spending fell by 14% in 2013. Most of these declines were in resources now needed such as professional training, public health, and a dependency fund for the virus' primary victim: the elderly. Cuts to Spain's healthcare for the old and for immigrants were so sharp that the prestigious medical journal, *The Lancet*, warned in 2012 of a coming "humanitarian problem."

Cuts like these directly affect workers and they have happened as more hospital managers promote flexibility and control over the workplace. A cross-national study of European nurses, for example, shows that Spanish nurses rank high on their disaffection with work scheduling, their inability to participate in policy decisions in the hospital, and inability to question managerial authority among other workplace grievances. Another study in *The Lancet* found that when nurses have to do "more with less" in Europe, the increased workload burden increased the rate of patients dying.

Similar grievances might be found in French hospitals. France too has been badly affected by the epidemic. As of May 26th, the death rate is 436 per million people—putting France just below the UK, Italy, Spain, and Belgium. For several months prior to the epidemic, French healthcare workers had been on strike protesting major cuts to public hospitals. Hospital workers reported increasing pressures to make their enterprises profitable and these workplace reorganizations made it difficult to provide adequate care.

Worker rights and support are critical. The loss of worker autonomy, devaluing gendered “care work,” and increasing precarity do not necessarily correspond to budget cuts but they are just as much a symptom of the neoliberal political project. In the case of Belgium, which has the highest per capita death rate in Europe,¹ healthcare spending has remained steady in recent years and Belgium hospitals and intensive care units have not been overwhelmed. Instead, most of the deaths are occurring in nursing homes. These workers, as the Belgian sociologist Geoffrey Pleyers points out, are too often forgotten and they lack proper protective equipment.

Neoliberal workplace control is also highly relevant within the UK’s National Health System (NHS). Since the Thatcher era, the NHS has gradually become more market-oriented. An OECD report from last year noted that spending increases for providers were conditional on workers increasing efficiency and productivity. The report notes the NHS is already quite efficient and these demands will burden overworked employees who have to do “more with less.” The proportion of doctors and nurses is below the EU average. Hospitals are also chronically understaffed, and lack important equipment needed for the pandemic including intensive care beds. The same OECD report notes, moreover, that hospitals are overly reliant on temporary staff—many of whom are immigrants and their futures are now in jeopardy because of Brexit. The UK, moreover, like Belgium, has ill-equipped and overstrained care home workers who are putting their lives at risk to do vital work in often poor and low-paid conditions.

¹ The high rate might reflect how Belgium counts their dead. Unlike other countries, Belgium officials can count deaths based on symptoms and without having done a test for the virus.

A Return to the Past?

How this will all be dealt with in terms of future social and economic policies remains an open question. There may indeed be calls for increasing healthcare investment, a preference for centralized planning, and a recognition of the rights and dignity of healthcare workers (and all essential workers). But despite the severity and suffering from this crisis, we should not underestimate the capacity of more powerful interests in Europe or elsewhere from asserting their economic and political interests at all costs.

There is evidence that other elites are perfectly comfortable securing the status quo. In the face of immediate human suffering, Wall Street, Downing Street, and the White House have not always hidden their preferences for the wellbeing of markets. Boris Johnson's chief advisor, Dominic Cummings, shrugged off the fate of "some pensioners" in the UK government's initial and tepid strategy of "herd immunity." Goldman Sacks CEO, Lloyd Blankfein, opposes a shutdown in the belief that an economic downturn would be worse for health than the epidemic. Donald Trump has also echoed these sentiments.

These ideas are based on a narrative that pits the economy against healthcare. The dichotomy is false because "the economy" is shaped by humans (who get sick and die) and human institutions. It is also dangerous because it implicitly suggests that the goal of economic growth trumps all others. This was how austerity was justified ten years ago. Fiscal hawks presented a narrative where the ultimate political goal was to preserve growth through budget cuts so the market will provide these needs down the road. It didn't. Letting this narrative frame political discussion again means we might lose even more.

There have already been warnings about unsustainable debt that require budget tightening. Weighing future economic scenarios in *the Daily Telegraph*, Roger Bootle says there are no painless options. Our only hope, he says, is "sustained economic growth combined with fiscal austerity" paid for by tax cuts. The epidemic has even been used to oppose reform and healthcare expansion. This is most striking in the United States. The US now has the highest number of Covid-19 cases. It is also in an election season. Bernie Sanders made an indelible impression on the political scene by proposing modest social protections in a country that has virtually none. Despite running a highly popular campaign with the American working class, the Democratic Party has shown no interest in any of his proposals or vision. This includes

Sander's signature plan of single-payer healthcare. The presumptive Democratic nominee, Joe Biden, is dismissing single-payer healthcare to address the epidemic, because, as he cynically says, it has not helped Italy. The same opposition is true in the liberal press which was highly critical of Sanders. *Politico's* Bill Sher, for example, excoriates the Left for using the crisis to push for healthcare reform.

In fact, this *is* the time to push for more healthcare spending and for the rights and interests of healthcare workers. Without a counternarrative to those calling for fiscal prudence and privatizing social services, we are at risk of repeating what happened after the last crisis. Years of austerity have left us ill-prepared for the coronavirus and exposed how vulnerable we are. The toll the virus has taken is grim, but it should remind us that healthcare is a human right and should never be compromised in the name of balanced budgets or profits.

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