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EDITORIAL

Austerity, Health and Ethics

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Since 2010 many European countries have used austerity measures as a way to address the budget deficit caused by the market crash and subsequent nationalisation of private debt 2 years prior. The idea behind such austerity measures was that by reducing government spending, funds would be freed to repay the public debt. In some countries, such as Greece, Ireland and Portugal, austerity measures were, to a large extent, externally imposed. For example, between 2010 and 2017, Greece received five bailout packages from the so called 'troika'—the European Union, the European Central Bank and the International Monetary Fund—and with each package the country had to implement a set of austerity measures to reduce public spending, including a reduction in healthcare spending. In other countries, such as the UK, the decision to implement austerity policies was self-imposed.

The UK embarked on an 'age of austerity' in 2010. The newly elected coalition government argued that was the best way to decrease the country's budgetary deficit and national debt. In the June 2010 Emergency Budget it announced £99bn in spending cuts and £29bn in tax increases by 2014–15. As Basu observes, austerity was presented to the public as a 'painful but necessary' economic strategy, quieting or even shutting down any critical or dissenting voices [3]. Originally it was declared that austerity measures will be completed by 2015–16. But it took another 3 years for the promise for an end to austerity to be announced. In October 2018 at the Conservative Party Conference the Prime Minister promised that austerity would soon be over [7]. The 2018 Autumn Budget included some increases in the budget for education, policing and healthcare. However, many suggested that, although welcome, this increase will not allow these sectors to effectively address the problems 8 years of underfunding has created [6]. In June 2019, the Health Foundation reported that without substantial upfront investment

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and increased funds for education, training, public health and capital investment the NHS long-term plan set out by the Government is far from achievable [5].

If at the beginning of the crisis there was disagreement about whether austerity was the right economic response to the financial collapse, in recent years, there seems to be a general consensus amongst the academic economists that austerity delayed recovery. Despite the dissenting voices from leading economists, austerity has been presented by the three successive UK governments between 2010 and 2018 as the only way 'to balance the books'. As Wren-Lewis observes, austerity policies allowed governments to legitimise unpopular policies regarding public spending, and 'achieve a neoliberal goal by the back door' [8]. It is now widely recognised that austerity policies had a detrimental impact on health and social services, and by extension on the people reliant on these services. On April 2019, the United Nations published its final report on poverty and human rights in the UK. The special rapporteur, Philip Alston, concludes in this report that 'Policies of austerity introduced in 2010 continue largely unabated, despite the tragic social consequences', including extreme child poverty, homelessness and decreases in life expectancy for certain groups [1].

A lot has been written in the past 10 years about the economic side of austerity, and a number of studies have examined the impact of austerity policies on healthcare in the UK. Although governments had declared that the NHS budget was going to be protected, the below-the-average increases it received meant that the spirit of this commitment was not kept [2]. Furthermore, budget-cuts in many areas of social care and mental health have had severe impact on NHS's ability to function [4]. Much less academic attention has been given to the 'ethical effects' of austerity in relation to the everyday experiences of healthcare professionals, the ways in which austerity policies shape the climates and provision of healthcare, and their overall impacts on patient and populations.

This special issue seeks to fill this gap and offers a collection of papers reflecting on and providing normative analysis of health care austerity, with particular reference to the experience and current situation of UK healthcare. The contributions are quite broad ranging but the first three papers centre around the topics of professionalism and medical ethics and looks at the impact of austerity on healthcare professionals and their everyday practice. Owens, Singh and Cribb analyse the implications of austerity for medical professionalism. Using the Bawa-Garba case as a springboard, they discuss the way professional ethics evolves under changing social and institutional conditions and draw attention to the ethical challenges of 'role construction'. Kerasidou draws from an empirical study conducted in A&E departments in England. This paper discusses the operationalisation of efficiency and its impact on the practice of empathetic care. It provides an analysis of the normative role structures, regulations and policies can play on the perception and practice of professional duties and obligations in healthcare. Morley, Ives and Bradbury-Jones turn their attention specifically to moral distress at times of austerity. They present a new conceptualisation of the term, and offer a critique of the position that individual resilience is the appropriate response to all instances of moral distress. They argue that resilience, especially in instances of

'avoidable' distress, places all responsibility on the individual and fails to respond to the structural, political and institutional factors that contribute to the problem.

The remaining two papers tackle much broader themes and seek, in different ways, to place austerity in international and historical context. Shahvisi's paper links the arguments for austerity with the 'hostile environment' against immigrants that has been prominent in the political and social discourse in the past few years. The paper explores the way in which the austerity discourse interacts with xenophobic discourses in relation to healthcare. It describes and analyses the manifested, operative, and target versions of the concept of "austerity" in relation to migrants in the NHS, and shows that the austerity discourse acts as a smokescreen for a more influential xenophobic discourse. Finally, Gainty's paper brings a different disciplinary perspective into the discussion about austerity in healthcare. She frames the discussion in the context of the history of modern medicine and the evolution of health care systems. Her argument is that the temporal nature of austerity focuses our vision on the now, but obscures the complexity of systemic healthcare provision. This paper presents a historical reconstruction of the systematization of healthcare and challenges the emphasis given to current situation of austerity as healthcare's bogeyman. Indeed it moves the discussion beyond austerity and suggests that, if the aim is to construct a more robust and virtuous healthcare system, it is important to focus on how the values of healing and caring can be translated into a comprehensive set of goals and systemic actions. This is a useful reminder that whilst we believe there is a great deal of scope for developing ethical analyses of austerity-related policies and practices, and more generally of the economic and social constitution of professional ethics, such analyses also depend upon us being ready to have clear-sighted debates about what combination of norms and values we would like to see instantiated in more ideal scenarios.

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