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Troubling Austerity: Crisis Policy-Making and Revanchist Public Health Politics

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Abstract

In February 2019 the city of Manchester opened a consultation for a proposed new public space protection order to strong community opposition. In response, the PSPO was initially tabled, yet amidst the COVID-19 Pandemic the order was passed by the council, granting sweeping powers to the Greater Manchester Police to effectively criminalize homelessness in the city. The impetus for the order was the sharp rise in rough sleeping, panhandling, and public drug use - all of which has been traced back to changes in economic and drug policy since austerity budgets were imposed in the UK in 2010. This lecture situates revanchist public health politics such as these within the wider context of policy-making under economic crisis. Linking studies of 'fast'- policy mobility to the materiality of health outcomes across European cities demonstrates how the rise and spread of economic austerity policies as best-practice solutions to the 2008 global financial crisis precipitated a steep downward turn in health outcomes across jurisdictions where such policies were imposed. It introduces the concept of *crisis policy making* - which refers to the socio-political conditions and processes through which government decision-making happens under the ever-increasing burden of ongoing and multiple crisis states. It lays out four aspects of crisis policy making, speed, opacity, revanchism, and experimentation. This lecture asks how a critical engagement with globally mobile policies in the context of crisis policy-making can uncover political contestations and power geometries governing responses to the resultant overlapping everyday public health, social and economic crises affecting urban inhabitants.

Keywords

Austerity urbanism, crisis, policy mobilities, public health

Introduction

Economic crises are good for doctors and drug dealers alike. Since 2008, cities have experienced increasingly negative health effects stemming from austerity including rising rates of illicit drug use, disease transmission, and lowered life expectancy (Rachoitis et al. 2015). While the link between austerity and negative health outcomes is established, less is known about cross-sector governance and policy processes contributing to shifting experiences of health and social service provision in cities. "Cities are," as Peck (2012, 629) writes, "where austerity bites." But what does that look like in practice? Urban crisis is generally understood to fall into three areas: economic, ecological, and social (Mayer 2020). However urban crises are also formulated on other political, social, and cultural axes. Health crises, for example, while having had profound effects on cities and urban life, are often neglected within these discussions (Ali and Keil 2008; Brown 2009). And yet, as recent health crises such as the opioid overdose crisis or Covid-19 have shown, they are caused by, inform, and are managed through multi-sector decision making processes, reaching beyond municipal governance but also inextricably tied to it.

S. Hall and Massey (2010, 59) have discussed urban crisis as a 'complex moment', considering implications of intersecting social, economic, political and cultural processes that shape space and how cities are built and experienced. Urban economic geographers have long focused on fiscal crisis and the decline of urban environments (Marcuse 1981; Piven 1984; Leitner 1989). Beginning in the 1970s, *urban* crisis has largely been understood through Harvey's analysis of the contradictions of capital. Fixed in rapidly deindustrializing cities, capital's inability to follow investment at pace led to the dual deindustrialization and depopulation of urban centres: economic crisis leading to social crisis (Harvey 1989). The focus on the urban roots of the more recent 2007 global financial crisis was diminished as political economists observed relatively rapid economic rebounds for the capitalist class, yet the materiality of the crisis was nonetheless rooted in the financialization of housing (Madden and Marcuse 2016; Fields and Hodkinson 2018). Such a materiality emphasizes the importance of socially reproductive infrastructures in cities, as well as elsewhere, demonstrating that the spatialization of crisis cannot be solely understood through a narrow focus in economics.

Social, cultural, and political scholars have also conceptualized the spatialization of crisis. Hall et al.'s (1979) *Policing the Crisis* explores racialized policing through the Gramscian claim that crisis is a space of agonism, where old systems die and new systems struggle to be born. Drawing on Gramsci's (1971) assertion of conjunctural crises as mundane, ongoing processes which do not change political-economic orders but rather reinforce them, Berlant (2011) puts forward the concept of the crisis-ordinary, referring to the processes by which socially reproductive capacities of communities and individuals are blunted or cut off through the slow violence of ongoing everyday crises (cf Linz 2021). Both economic and cultural approaches have engaged the spatio-temporal nature of crisis. And while there is debate and often division between theorizing crisis as event and as an ongoing process (Roitman 2014), I argue that thinking about urban crisis at the interstices of event and process, bringing together the social, the political, and the economic, can offer ways to extrapolate new political possibilities for more progressive, socially just, and radically alternative urban geographies. Crisis as an event can puncture the crisis-ordinary, opening up new spaces and political possibilities for urban futures (Linz 2021). Similarly, Doucette's (2020, 327) call for a Gramscian analysis of political will in political geography asserts the importance of translating concepts "into their real, practical forms of historical existence, as socially particularistic and temporally limited." Urban crisis is one such concept.

Drawing on my own research from 2015 to the present, I animate this argument by developing the notion of *crisis policy making*, which refers to the socio-political conditions and processes through which government decision-making happens under the ever-increasing burden of ongoing and multiple crisis states. I argue that there are four aspects of crisis policy making: speed, opacity, revanchism, and

experimentation. Building on Peck and Theodore's (2015) notion of 'Fast Policy', the speed at which decision making happens during crisis increases, what was deemed impossible a month or even a week earlier can be passed into law overnight. Second and related, decision-making processes under crisis are often opaque. The lack of transparency is often excused through the invocation of exceptional circumstances, of emergency and the need for leadership and action (Agamben 2005). Third, crisis policy making is often reactionary – decisions are made in response *to* rather than planning *for* crisis, and those responses are most often revanchist, making visible the more-often slow structural violence of the state, and targeting people and communities often seen as problematic, whether they be climate protestors or homeless people (Smith 1996; Slater 2018). Finally, crisis policy making is characterised by experimentation. The emergent character of crisis states mean that space opens up to implement new solutions to long-standing as well as immediate problems. The experimental character of crisis policy making has a two-fold effect. We have often seen crisis used for experimentation to deepen new forms of neoliberal governance, dismantling the social infrastructures of the state (Broto and Bulkeley 2012; Karvonen et al. 2013; Millington and Scheba 2021). Yet, experimentation also allows for the emergence of new forms of progressive or even radical solidarities, practices, and policies that have the potential to reinstate and reshape social infrastructures, enacting a politics of care in the city (Lawson and Ellwood 2018; Ruez and Parekh 2019).

In this contribution, I evaluate both sides of experimentation in crisis policy making, drawing on examples from my comparative research on how austerity has affected access to public health services for marginalized communities in in Athens, Budapest, and Manchester. In order to gain an empirically rich understanding of the current political moment, which is complex and fast moving, I argue that it is essential to theorize with a framework for understanding the politics of public health that takes seriously a policy mobilities approach. By which I mean the social processes of circulating ideas and the people and resources that go into creating powerful ideas, like austerity, that get implemented through policy (Peck and Theodore 2010; McCann and Ward 2011; Temenos and McCann 2013). I then present findings from my current research to demonstrate the importance of placing the policy process into broad assemblages of political conflicts and everyday experiences of public health.

This intervention is based on primarily my relational comparative project: *Mobilizing Austerity: The urban politics of public health after the global financial crisis*, coupled with ongoing research on the formation and effects of intersecting urban crises. I draw on mixed qualitative methods including interviews with policy makers, advocates and activists at local, national and international levels, as well as the healthcare service providers in Athens, Budapest, and Manchester, coupled with observations and policy analysis of key government documents. The project is a relational comparison (Ward 2010; Robinson 2016; Hart 2018) examining the networks and institutions involved in promoting austerity as a concept, its interpretation, and implementation in Athens, Budapest, and Manchester, and how actors in these sites negotiated austerity policies as they were implemented and experienced. A relational comparative approach allows a conceptually and empirically deep analysis of how austerity has been mobilised in many different forms (González et al. 2018). Greece had austerity imposed on if from the Troika, a group comprised of the IMF, the European Commission and the European Central Bank, whereas in the UK, it was introduced by a government coalition, and in line with the conservative party's long-time agenda to roll back the welfare state. In Hungary, the country has never declared austerity as a policy in name, but since 2010, austerity measures have been put in place with increasing rigour, under a different discourse; a deliberately mixed discourse of far-right nationalism and protectionism coupled with a modernization, rather than globalization, rhetoric. In thinking about austerity as a globally mobile ideology, a comparative approach is an important way to understand the politics and processes that go into grounding it (Temenos and Ward 2018). My work asks what insights can we gain when centring the relationship of multiple movements; multiple mobilities, within and across space? This question is

important because often when policy is studied, it's done so out of context. Scholarship tends to silo policy as a bureaucratic part of a formalized political process. And yet, policy making is more than an automated process, it is made by people to impact on people and places in both known and unexpected ways. Policy is situated within a particular set of historically informed social relations.

It is important to note that the vast majority of this research, and this lecture was undertaken by August 2019, before the Covid 19 Pandemic. The subsequent write up and publication of this talk was held up by the increased workloads resulting from the Pandemic, a maternity leave, and three rounds of industrial action. Like all of us, I found myself living through crisis policy making, not just studying it. This paper does not discuss Covid and its effects in any detail. In part because the Pandemic is ongoing. We are not in a post-Covid state and may not be for a while. But also, in part because this paper, and the ideas presented within it have not yet been changed by Covid, the Pandemic providing further examples of crisis policy making on which to draw. Early on in the Pandemic, the end of austerity was hailed as a potential venue to 'build back better', yet in some places, including Athens, Budapest and Manchester, it remains in multiple forms, coupled with new cost of living crises that will likely exacerbate existing urban inequalities. However, crisis policy making during Covid has also shown that solutions to issues of homelessness or access to care can be enacted through political will and appropriate resourcing. Therefore, the effects of the Covid 19 Pandemic are ongoing, and the provisional space that it has opened through crisis policy making are not yet forgone conclusions.

Intersecting Crises

Current interconnected financial, health, and social crises can be characterized as both long and fast. The ongoing financial crisis stemming from the 2007-2008 economic crash, has led to a series of economic disasters that have in turn affected many other crises including health and social crises. It is long because these processes have been ongoing for over a decade and fast as the ups and downs of national and regional economies have often been sudden and harsh. This is a direct result, not only of the crises, but also of the policy responses to them, which have largely been austerity measures (Peck 2012; Tonkiss 2013; Davies and Blanco 2017; Davidson and Ward 2018). Austerity in this context is the radical application of neoliberal logics to national and local government budgets. Drastic cuts to budgets are made across all policy sectors but sectors which tend to be particularly hard hit are social care and health, even when health budgets themselves may be ringfenced.

For example, between 2010 and 2018 the national government in Greece enacted twenty-nine rounds of tax increases, spending cuts and economic reforms, all under the impetus of austerity measures imposed on them. In the UK, there have been 37 billion pounds in cuts to social security, and 49.1 percent cuts to local government funding (Butler 2018; UK Parliament 2019). This is particularly important because on a population health level, outcomes and access to health services are directly linked to social wellbeing. And in researching the politics and access to health services, one can't only look at health policy and budgets. Social policies and programmes, and their associated funding are an essential part of the equation. The UK is a good example of this. Despite austerity first introduced by the government in 2010, the healthcare budget was ringfenced and has on average grown by 1.3 percent a year, which is due to increase by 7 percent between 2015 and 2021. More money for the NHS, good news, right? Only if one looks at the numbers in the health budget.

The increase in funding is much lower than the increase in the demand for services. The Institute of Fiscal Studies, a UK based research institute focusing on taxation and public policy, calculated that, with the increase in demand, per capita spending will actually fall by 1.3 percent. So, it's not making up the shortfall in the need for more services. What people are experiencing is an increase in wait times for treatment and an increase in wait times for admissions to A&E (C. Baker 2020). Coupled with increasing

staff shortages, which have been exacerbated by Brexit, this has led to the British think tank, the Kings Fund to call the consecutive winter crises of since 2016 an ongoing emergency. Even before the COVID 19 Pandemic, the NHS has been in 'full blown' crisis (Kershaw 2018).

Rising use of the NHS is linked back to the cuts to the social care budget, which funds social support for things such as ageing in place, mental health care in the community, and early childhood support for children and their carers – particularly women. When those social programmes were cut and that *care-in-place* fell away, people's health status worsened and they began needing NHS services in greater numbers and with greater frequency. The rise in service need has disproportionately affected poor communities because they are more likely to rely on state services and less able to pay for private alternatives (Baeten et al. 2018). This situation is similar in Greece and Hungary.

Despite austerity policies not forcing cuts to the NHS budget in the UK, decisions to cut budgets elsewhere have *de facto* cut access to the NHS by limiting its capacity and per capita spending. This is just one example demonstrating how both healthcare and austerity crises are linked, and so too are policy decisions that stem from the implementation of austerity practices. In 2018 the UK Chancellor announced that the 2018 budget would see an end to austerity as policy, yet for austerity to effectually end, the government would need to raise an additional £19 billion a year (Emmerson et al. 2018). Therefore, there's a disconnect in government rhetoric and material conditions which indicate ongoing crisis.

Beyond budgetary and policy terms, there are also the material and biophysical crises linked to austerity measures. For example, cutting welfare payments during a time of record unemployment, coupled with increasing financialization of the housing market, which is happening in both Greece and in the UK, has led and is still leading to a drastic rise in homelessness and a housing crisis (Watt and Minton 2016; Fields and Hodkinson 2018). This in turn puts people into vulnerable positions. Intersecting crises also take a toll on mental health, all of which – at a population level - leads to higher drug and alcohol use and the likelihood of engaging in underground economies, among other risky behaviours. In turn austerity has contributed in large part to the HIV and Hepatitis C outbreaks and the overdose crises that many European and other cities are experiencing. The 2021 UK Office of National Statistics' drugs death report shows the highest number of deaths due to drug overdoses since records began in 1993 (ONS 2021). The spatial distribution of these deaths is unsurprising: people living in northern UK cities are 50% more likely to die of a drug overdose than those living anywhere in the south. Cuts to funding for drug treatment services have been at 27% since austerity began in the UK and, over 50% of the services cut are northern. These crises are connected. In this context of multiple and ongoing crises of austerity, it is imperative to understand how austerity as a political idea is mobilised and implemented and its effects across different urban contexts.

Mobilizing Austerity

Since 2008, scholars interested in the relationship between global economic processes, policy, governance, and place have foregrounded the mutually constitutive relationship of mobile policy and place-making (McCann 2008; Peck and Theodore 2010; McCann and Ward 2011; Temenos and McCann 2013). This work focuses on social processes of circulated models and ideas among places and importantly, the political struggles of implementing these models and ideas into specific local contexts. It takes a global relational approach and aims to bring together focus on the macro level concerns of political economy with a fine-grained analysis of local policy and politics (Massey 2011; Allen et al. 2012).

Bringing this perspective to bear on the concept of austerity, and drawing on recent work on austerity urbanism has enabled me to draw insights into contemporary policy making and its effects on access to public health services. Here I focus on access to services for vulnerableized communities.

Austerity urbanism is a body of work that has emerged post-crisis and its concerned with austerity as a policy and as a social condition (Peck 2012; Tonkiss 2013; Fuller 2017; Davidson and Ward 2018; Gray and Bardford 2018). It is focused on how austerity shapes contemporary cities through the role of intensified localism under neoliberal state governance. In bringing these two bodies of work into conversation, I examine the role of crisis in urban politics and policymaking, troubling ideas of austerity as all-encompassing or inevitable.

Davies and Blanco (2017) in their analysis of six different cities where austerity has been implemented, have shown that places with a history of contentious politics are more likely to weaken the foundations of neoliberal austerity, thereby creating a potential base for broader, perhaps more progressive regime change. While austerity tends to strengthen neoliberalism and undermine participatory governance, resistance to it has the potential to forge new and sometimes unexpected solidarities. It's especially important to emphasise this in theorizing radical geographies of hope (Lawson 2007). Riffing on Marx's famous maxim, Castree et al. (2010) assert that the point of theorizing a geography of hope is to change the present moment for better. I'm not arguing that we should ignore the seeming hegemony of neoliberal capitalism. It is however, important to examine the progressive and sometimes radically transformative politics and possibilities arising in relation to conditions of austerity in order to enact the possibilities of alternative futures.

The rest of this discussion focuses on how the politics of public health play out in relation to crisis policy making, highlighting both the troubled moment of a resurgence of revanchist urban politics, as well as hopeful examples of healthcare solidarity, a point on which I end this intervention. Austerity is not a new concept. Living at or below one's means due to a lack of resources as well as a moral or aesthetic position has been advocated for by philosophers, politicians and religious leaders for centuries (Blyth 2013). More recently, the years following World War II were known in the UK as the Age of Austerity, and during this time, the UK was required to liberalize its economy and remove trade barriers in order to access Marshall Plan funding to rebuild. The form of austerity that we are familiar with today, the stripping of government budgets, privatization of services, and the rise of taxes is modelled on the structural adjustment programs forced on many countries in the global south by the IMF and World Bank in the 1980s in exchange for loans to modernize infrastructure and pay off debts (Lütz and Kranke 2014; Bigger and Weber 2021).

The memoranda of understanding under the current Economic Adjustment programs agreed by multi-level governance arrangements, which generally include the IMF, the European Commission, the World Bank in the case of Hungary, and the European Central Bank in the case of Greece, are 'serial reproductions' of structural adjustment policies of former years (Harvey 1989; T. Baker and Temenos 2015). These policies and programs require cuts to publicly funded healthcare systems or, where health budgets were ringfenced, cuts to the associated institutions and policy sectors such as social care and early childhood education, which in turn have significant effects on social determinants of health. Budget cuts were enforced in Greece and Hungary despite the IMF's previous acknowledgement that cuts to these sectors should be off limits. When they came into effect, enacted on already chronically underfunded systems, it was unsurprising that a series of health crises ensued. Both Greece and Hungary, for example, experienced unprecedented HIV outbreaks directly liked to cuts to needle exchange programs and other drug treatment services (Malliori et al. 2011; Tarjan et al. 2015).

Cuts to the services and outbreaks were centred in Athens and Budapest respectively. In her work on structural adjustment and austerity in Asia, Gosh (2019) argues that the persistence of economic adjustment programs, despite their failed outcomes are due to a lack of accountability for financial institutions such as the World Bank and IMF. Peck and Theodore (2015) have also documented how the ideology of neoliberalism remains strong within these institutions despite policy failures. This work

emphasises that failure is a power-laden discourse as well as material outcome, revealing actors involved in labelling policies successes or failures, and indeed what counts as failure (McCann and Ward 2015; Temenos and Lauermann 2020). Lesson drawing for the failed programs does not conclude that neoliberal programs increase poverty outcomes, but rather that the countries implementing the reforms did not do so correctly or to a wide enough extent (Peck 2002; Temenos and Lauermann 2020).

Oliver Blanchard, former chief economist at the IMF during the 2008 crisis, when discussing the failures of the Greek program, observed that:

> We believed that a small primary surplus, increasing over time, was absolutely necessary to maintain debt sustainability. Having examined the budget closely, we did not see how this could be achieved without VAT reform to broaden the tax base, and pension reform to put the pension system on a sustainable footing. On these, *our views coincided fully with those of our European partners*. (Blanchard, 2015, emphasis added)

The persistent belief in neoliberal economic reform, stubbornness to enter into discussions that another way towards debt relief might be possible, and the lack of institutional accountability by governance partners in the European Commission coalesced, enabling a policy with known negative social outcomes to be rolled out across struggling European countries. What implications does this have for local politics? For one, a rise in revanchist responses to public health issues. Geographers have noted that with austerity has come an increased revanchism in urban politics (Lees et al. 2010). However, as Lawton (2018) demonstrates, studies engaging with the revanchist city remain concerned with research on gentrification, housing and homelessness. Slater (2016, 29, emphasis added) notes however that "the revanchist city is an arena where those at the top of the class structure are determined to maintain and augment their privilege of their position *via all sorts* of aggressive political tactics, institutional innovations, legal frameworks, and *policy experiments.*"

When held up to the urban politics of public health, such as the siting of health services like drop-in clinics, the ways and places in which diseases such as HIV or Hepatitis C are treated (for example the distance people need to travel to see a doctor), or the enactment of public space protection orders meant to criminalize homelessness under the guise of preventing public health crises, it is evident that the violence of the revanchist city is made explicit through public discourse and actions. The UN has condemned the UK government for its 'mean spirited' approach to people affected by austerity (Alston 2018), there are increasingly police (rather than paramedic) responses to overdose crises, charities have to change hours and location because of budget cuts and rent increases, and there are far right attacks on health services. For example, in March 2019, Positive Voice, a large HIV/AIDS service organization in Athens was attacked and their building set fire by a fascist group. Similar acts of arson have been committed against refugee housing squats and other spaces of solidarity for marginalized communities in Athens. The violence of austerity politics is not only structural, it is explicit.

In the midst of increasing scarcity of resources, less consideration is shown to those communities already experiencing marginalization when it comes to the distribution of health resources, which repeatedly came up in interviews. For example, one service manager in Manchester, discussing cuts to the social care budget, observed:

> When the budget cuts come down… there's nothing you can do to fight them. You need to manage them. And of course, the best-case scenario is you hope to work together and make the cuts in ways that will least affect everyone. But that's not … [*long pause*]. You have to manage it, and of course everyone thinks their program is most important. They want to save their program and their people [jobs]. So, judgements get made and questions start coming up around deservedness. (Interview, Service Manager, Manchester 2017)

Deservedness was a pervasive discourse throughout interviews in all three cities. When budgetary decisions are assessed on the question of who is more deserving of care, it evokes the spectre of responsibilization, an individual needing to care for themselves before they can receive care (Glasgow and Schrecker 2015). In a socialized health care system, allocating care on the basis of 'deservedness' also brings into question who is included in the 'public' that such systems are meant to serve. In turn, there is less space to acknowledge structural causes and social determinates of ill health brought on by the very logic and condition of austerity, which is constantly reinforcing itself.

And yet, revanchist urban policy is not as straightforward as it seems. Those who enact policy on the ground, so often the middle-class service providers, are not necessarily operating on assumptions that entire communities don't deserve care due to their position in an immutable underclass (Blokland 2012; Di Feliciantonio 2021). Rather, as the quote above demonstrates, deservedness comes into play as a discursive strategy when austerity policies manufacture scarcity. Discussions of deservedness, an ongoing discourse in health and social policy, takes on new urgency in crisis situations and it is more frequently weaponised as 'common sense,' foreclosing debates on alternative policy responses. It is important to recognise, however that "discourses and policy papers do not constitute social life until they are practiced on the ground." (Blokland 2012, 503). This is the hard-line, punitive, and messy political context in which access to health care is played out and in which policy decision are made.

Crisis Policy Making

Continual and ongoing crises and revanchist politics emergent both from within government institutions and non-state stakeholders have led to what I call crisis policy making. As I noted in the introduction, there are four aspects of crisis policy making: speed, opacity, revanchism, and experimentation. In their study on fast policy, Peck and Theodore (2015), following Harvey (1989), argue that the cyclical crises of capitalism are compounded in ever diminishing timeframes through time-space compression, and policy makers are compelled to respond with increasing speed. Policies therefore, either need to be adaptable or replaceable. On the one hand this has fuelled a rise in policy mobility, in searching for policies that are known to 'work', best practice (McCann and Ward 2011). On the other hand, the speed required of policy responses also contributes to increasing political uncertainty. With policies rapidly changing, sometimes annually as was the case in Athens during the financial crisis or daily in each city during the first and second waves of Covid, local government and communities are unable to build long-term visions or plans, nor are they able to ensure that services will remain in place or fit for purpose.

The second aspect of crisis policy making is its opacity. The suddenness of crises and the states of exception invoked to respond to them means that regular democratic processes of policymaking are either sped up or done away with altogether, decision-making by fiat. It can also become "difficult to maintain the improbable speed required for reforms to take shape" while in a state of crisis (Lorne 2021, 6). The lack of transparency and stamina also contributes to uncertainty, often meaning health programs, especially public health outreach programs, quickly become understaffed and eventually unsustainable. Third, crisis policy making is often revanchist. It is a reactionary response to a specific crisis or particular assemblage of crises that presents itself in the moment. Revanchist policy responses are fuelled, as Jessop (2012, 33) notes, by "the widespread belief that 'everyone' is to blame because of generalised 'greed' based on the financialization of everyday life in the neoliberal economies." The framing of crisis as caused by individual greed and overconsumption sets a stage for enacting widespread austerity measures that in turn produce negative social and economic outcomes for cities globally.

And fourth, crisis policy making is experimental. It is this fourth element, I argue, that we can look to in order to trouble austerity as a condition. The global financial crisis in 2008 precipitated a series

of pro-democracy social movements globally. Across #Occupy, the Arab Spring, to the Umbrella Movement and others, there was a growing sense that the neoliberal experiment had reached its limits and that there was space for new forms and practices of governance to emerge. While radical transformation did not materialize through revolution, through what I have elsewhere called 'everyday proper politics' - the ongoing mundane political interactions between the state and society that include but are not limited to street protest - there *was* a shift in governance spaces and debates about what alternative political possibilities might exist (Temenos 2017). Progressive alternatives are perhaps most widely recognizable in the new municipalism movement and urban governments such as Barcelona en Comú (Russell 2019; Davies 2021). However, there are numerous other experimental practices that have served to materially make a difference in the outcomes of crisis affected cities such as solidarity clinics and pharmacies, which I discuss below, and in reframing and pushing forward debates on punitive laws; for example repealing the harshest austerity policies in Greece that had prevented people accessing health insurance, or more publicity on political debates about drug legalization and regulation in the UK. Precisely because of the speed, opacity and reactionary nature of crisis policy making, there is an opportunity for experimentation and change during times of urban crisis. Programs that may not have been politically tenable even a month earlier, are not only considered, but quickly put into place. The remainder of the paper demonstrates how crisis policymaking operates in practice in order to illustrate the pitfalls and possibilities of public health service provision within European cities, taking examples from each place in turn.

Budapest

Public health provision in Budapest deteriorated rapidly post crisis. Prior to 2008 Hungary's post-socialist economy was relatively strong. However, the shock of the 2008 financial crisis was particularly acute due to heavy foreign currency debt. And as a result, Hungary was the first EU country to receive a 20 billion Euro loan from the IMF. In addition to cutting pensions, raising the retirement age, freezing wages for government employees and parring back state-subsidy programs, loan repayment conditions also led to significant cuts to the 2008 national health budget. Although subsequent health spending has remained stable, extra stressors on the system have included increased unemployment and increased urbanization, particularly in Budapest. There is also increased demand for low-threshold public health services including primary care centres, drop-in health clinics, and needle exchange programs which has been growing since 2011. Local authorities, including Budapest, own their hospitals and most other health facilities, and are responsible for healthcare services, which has led to geographically unequal care provision and access, not only between urban and rural places, but also within cities. Since 2010, when the right-wing Fidez government won landslide victories in both national and municipal elections, the government has pushed a privatization agenda in healthcare, transitioning the system to an explicitly single payer model in 2011.

From 2010-2013 parts of the public health budget, which was split across health, social care, and law enforcement budget packets, were suspended as the newly elected government reviewed and, in most cases, replaced policies dealing with public health and social care. Therefore, despite no significant change in healthcare spending percentages, budget allocations have been significantly reoriented away from public health and primary care services. In that time and subsequently, many primary health facilities as well as public health outreach for marginalized communities, such as the Roma, street youth, sex workers, and people who use drugs, have been shuttered due to funding cuts which have, in part, been attributed to austerity budgets.

For example, in 2010 the drug treatment budget was halved. It was one of the first political moves by the Fidez government, coupled with a halt and review of the new National Drugs Strategy which had been due to be rolled in 2010. The justification for this was also budgetary. Citing the IMF bailout,

politicians argued that with budget cuts, a new drugs strategy would have to be implemented in line with what was economically feasible. These actions were coupled by a war on drugs, tough on crime government rhetoric. Hungary had, up to 2010, a successful public health policy. During the AIDS Pandemic in the 1980s and 1990s, Hungary was a notable exception to the high transmission rates in post-socialist countries. It was also the only post-socialist country that had rapidly and universally implemented needle exchange in its cities. Hungary's public health harm reduction approach to drug policy was seen as a model of success in the region. In 2000 a public health first approach, rather than a criminalization approach, was written into the National Drugs Strategy. This approach was largely credited as keeping Hungary's HIV rates the lowest in the region for two decades between 1985 and 2005 (Gyarmathy and Neaigus 2005). The rates of HIV remained low until 2012 when the effects of the budget cuts came into play. The Fidez government took steps to ensure that harm reduction policy was made to fail in achieving its intended aims in an example of what Wells (2014) identifies as *policyfailing,* the processes and politics of orchestrating the failure to launch or reach policy targets, effectively making policies fail. Almost thirty years of successful policy implementation had failed due to ideological opposition in the face of clear evidence of successful social, fiscal, and public health outcomes.

A new drugs strategy was not issued in Hungary until 2013 along with a revised penal code that had significantly increased penalties for drug use, and by then the damage had been done. The closure of services had begun almost immediately in 2011 and 2012. And by 2014, rates of HIV and Hepatitis C began to rise at alarming rates. The rate of Hepatitis C doubled between 2011 and 2014 among injection drug users (Gyarmanthy et al. 2016). Two of the largest six fixed site needle exchanges closed in Budapest, severely limiting service provision. Many of the health services which were operating in the VIII and IX districts and on the outskirts of the city have transitioned from fixed sites to mobile outreach teams, which has significantly impeded the local community's access to health services.

In Budapest crisis policy-making is compounding the austerity crisis by creating new crises where before there were none. Suspending the drug policy in the name of austerity was politically convenient for the government, where it aimed to be seen to be acting tough on drugs by forcing the closure of needle exchanges and drop-in services. However, having no drugs strategy in place for four years meant that already reduced funding was not guaranteed year on year, nor were services able to plan further than the fiscal year. While there was some improvisation, for example former staff at the shuttered services teamed up with a local church to put together an outreach program, it is based on volunteers and donations, with no paid employees or budgets for supplies, and therefore provision remains ad hoc. Nor was it enough to fill the gap left by the closure of scheduled and funded services. The results of these crises have been an increase in drug use and disease transmission (Gyarmanthy et al. 2016), and a sharp decrease in access to health services under austerity.

Manchester

Health and social policy in Manchester operates from within a different, more subtly revanchist context. In Manchester there's been a focus on experimentation. Austerity was introduced in the 2010 national budget, 85% of which consisted of spending cuts reducing expenditure by £85 billion, affecting the National Health Service (NHS) and Social Care significantly (Reeves et al. 2013; Lorne et al. 2021). Unlike Greece and Hungary, the UK government proposed and passed an austerity budget rather than having it imposed. Therefore austerity in the UK, being presented as the only option, was less contentious than in Greece and Hungary. However, the backlash against planned cuts to the NHS was great enough to temper sweeping measures outlined in the original 2010 budget. Despite the widely publicized backtracking on planned cuts to the NHS, other Local Authority cuts have been 'inevitable' due to budget constraints. Cuts of 6.2% to public health grants and 14% to social care leave UK cities searching for resources to deliver on increased demand for services (Reeves et al. 2013).

It is in this context of austerity that the UK has begun a process of devolving budgetary powers to local and regional authorities, starting with a 2014 deal in Manchester, where a six-billion-pound combined health and social care budget is being administered by the newly formed Greater Manchester Health and Social Care Partnership. Despite having no statutory responsibility for health, it is presided over by Manchester's first elected mayor and a former health secretary, Labour's Andy Burnham. The partnership can administer budgets, but cannot, at least formally, effect NHS policy. The Manchester model is likely to serve as a forerunner to the five other regions set to take over their own health budgets in the coming years. And despite protests lead by groups such as the People's Assembly or the #SaveOURNHS movement, contractualization has been a large part of the devolved NHS budget in Greater Manchester.

At the same time as the devolution deal was being hashed out between the treasury, NHS England and local government leaders, Greater Manchester was also the site of a pilot program for the new Universal Credit system, the reorganization of six means-tested state benefits into a single payment. This new benefit has been controversial, and its implementation has proved to have serious negative consequences for people already on benefits for a number of reasons, including the 6 week (reduced to 5 week) waiting period for the first payment (Klair 2020). It is in this context that the effects of 'everyday austerity' (S. M. Hall 2019) were acutely felt. The gap between the end of the old benefits system and receiving the new ones put financially precarious tenants into rent arrears contributing to the 62 percent increase in homelessness between 2014 and 2015. Additionally, pre-existing pressures from the bedroom tax and other benefit sanctions forming part of the Conservative government's welfare reform agenda has been fast-tracked. A concurrent rise in drug use, including the introduction of new synthetic substances such as spice (synthetic cannibinoids), has led to a crisis not only in homelessness, but also in homeless health care.

During a 2016 homeless health audit, 55% reported tri-morbidity, or having mental health, physical health and substance use issues. 57% had been to the A&E within the year and 63% who were admitted to the hospital were discharged to the streets, which greatly increases their risk of returning to care via A&E (Pathway 2017). The emerging Greater Manchester Health and Social Care Partnership commissioning strategy was seen by advocates as an opportunity to ensure a response to homelessness was embedded within the design and implementation of the devolution deal, which would improve health inequalities – a key objective of devolving the health budget. The Greater Manchester Combined Authority's 2021-2026 Homelessness Prevention Strategy mentions healthcare and devolution, but to-date it is too early to know if initiatives will be funded.

Homeless health is a complex issue. People becoming homeless with pre-existing mental and physical health issues, often have those issues exacerbated by the uncertainty of homelessness. And people without pre-existing conditions who become homeless can often develop complex and overlapping health issues. Housing or lack thereof is one of the strongest social determinates of health (Swope and Hernández 2019). Therefore, homelessness became a cornerstone of Burnham's campaign when running for mayor. A number of initiatives have been sponsored under this banner. The very visible crisis of homelessness in Manchester has also meant that there's a political will to push for change, however the consensus on how best to do it and whether initiatives will be successful is hotly debated.

In addition to the 'A bed for every night' campaign rolled out in 2019 and aimed at providing a shelter bed for each of Manchester's 500 rough sleepers; there's the Homeless Friendly campaign, which focuses on educating both GP surgeries and those without an address on their right to access GP care, and two housing first pilots. Like austerity, housing first is a globally mobile policy and widely considered best practice by housing advocates (T. Baker and Evans 2016). It is predicated on taking the hardest to house, people who've experienced chronic homelessness and multiple health and addictions

issues and provide them secure housing with wrap-a-round health and social services tailored to their individualized complex needs. They have been popular in part because of their success and in part because they advocate socially progressive ideas on housing which, according to T. Baker and Evans (2016, 32)

> align with common features and preferences of (urban) neoliberalisation projects, some of which include: (1) a discursive and material emphasis on individual pathologies (i.e. mental illness, addiction, physical impairment) over structural causes of homelessness, (2) the premising of intervention based on the fiscal savings thought to result from addressing a 'high cost' sub-group of the homeless population, and (3) the realisation of 'clean and safe' streets by removing a small but highly visible type of homeless person and their behaviours from public view.

And so, it is a popular policy model under austerity.

However, without continuous financial investment by government into the project, the housing first model will not necessarily succeed. The pilot programs in Manchester, are only guaranteed funding for three years. This has led to frustration on the part of health professionals and housing activists alike. According to one GP:

> It's still frustrating because you still hear all this money being thrown at homelessness and it's thrown at accommodation approaches. Housing first, everybody goes on and on about housing first, which I understand has an evidence base to it, but they put people in a house but they don't do anything about the drug service, they don't do anything, and its ability to do anything about our service, they don't do anything about support services. (Interview, GP, Manchester, 2018)

A Manchester homeless advocate and policy maker also stated:

> …it's not a panacea… My concern is that it's taken on as the one approach because it's an easy way for a government that has fragmented a system to try and show that it's put it back together… And my concern is that the funding at the end of the programme as well, you know, the whole point is that those services should never stop for that individual if they need it to and that's much more expensive than the current system, but if it's effective, it saves us money in the outer system, but where is that going to come from in times of austerity? (Interview, Policymaker, Manchester, 2018)

The scepticism from people already working on homelessness issues from a health and housing perspective is not unfounded. In February 2019 the city of Manchester opened a consultation for a proposed new public space protection order effectively criminalizing homelessness. It received strong community opposition and initially the PSPO was tabled in response, yet amidst the COVID-19 Pandemic the order was passed by the council granting sweeping powers to the Greater Manchester Police. The impetus for the order was the sharp rise in rough sleeping, panhandling, and public drug use - all of which has been traced back to changes in economic and drug policy since austerity budgets were imposed in the UK in 2010.

The framing for it (before and during Covid) was also based on public health logics of stemming used needles in the streets and the chronic problems of public urination and defecation, which increased with the closure of public toilets under austerity. Crisis policy-making in Manchester demonstrates a lack of coordination across a wide assemblage of health and social issues. Since the Covid 19 Pandemic, Manchester has taken advantage of new temporary funding streams and made progress on reducing homelessness, by estimates of 52%. Yet it's unclear how municipal and regional health and housing

strategies will come together to affect positive change on homelessness in the long run, and the willingness to experiment, for example with housing first, is in danger of failing due to this lack of coordination and the speed at which funding can be found for pilots, but not for long-term implementation.

Athens

Athens is yet another story. The negative effects on health outcomes and access to health services in Greece under austerity are well documented (Karanikolos and Kentikelenis 2016; WHO 2016; Sparke 2017). It is generally accepted that the austerity measures imposed on the country have been the most severe in the EU. Athens represents an extreme case of austerity, and therefore it is not representative of austerity urbanism in European cities. However, it has not only magnified negative consequences, but also the political alternatives emerging in the context of crisis, and thus remains a vitally important case. Since 2009 the Greek economy has reported the highest debt in the European Union at 25.6%, and is currently in the process of receiving its third and final financial bailout under rapidly increasing and nationally contested austerity measures. The Greek crisis was triggered by a perfect storm of the 2008 global financial crisis, existing structural weaknesses in the Greek economy, and its chronic underreporting of its national debt. Between 2010 and 2018 the national government enacted twenty-nine rounds of tax increases, spending cuts and economic reforms - austerity policies. These moves were conditions imposed from the loan package received from the troika the IMF, the Eurozone, and the European Central Bank in 2010, 2012, and 2015. Between 2009 and 2013, spending on health was cut by 32%. Public health programs, including medical outreach, planned increases in community health clinics and needle exchanges in Greek cities were among the first casualties of the budget cuts, which in turn led to a rapid increase in disease transmission.

In Athens alone, a 2011 outbreak of HIV saw the rates of infection increase by an unprecedented 1000 percent. (Davies 2012). Malaria appeared in the country in 2013 for the first time in forty years, and suicide rates have increased by 40 percent since the crisis started (Rachiotis et al. 2015). The declines in health linked to the financial crisis were exacerbated by pre-existing record unemployment and poverty rates. Athens is also home to 40 percent of Greece's population and has a national universal health system, which is split between public and private provision. Primary and public health care delivery is through district health clinics. In 2011 austerity measures imposed limited those unemployed to one year of access to national health insurance. Thereby cutting universal health coverage for a quarter of the population, who due to chronic unemployment within the depressed economy, could not afford to pay for private care. This was coupled with pay cuts and a hiring freeze in the public sector including publicly funded hospitals. With demand for private services falling and a lack of entrance into the publicly funded system, many health professionals moved to other European countries, particularly the UK and Germany. Citizens could not afford to access care, and there were fewer people qualified to care for them.

What emerged in the gap in care is perhaps one of the most striking forms of solidarity that has come out of the crisis. Solidarity health clinics and pharmacies, volunteer clinics that began operations in cities around Greece, with a concentration in Athens. They are primary health care clinics providing preventive, chronic and emergency healthcare, vaccinations and prescription medicines to, mostly, uninsured people. They began operation entirely outside of the state, political parties, or international NGOs. There are estimated between 92 -137 clinics operating throughout Greece, and about 50 within Athens. The clinics are entirely volunteer run and the majority operate through horizontal decision-making structures, most often through a general assembly made up of volunteers and patients (Evlampidou and Kogevinas 2019). The largest clinic sees on average 1300 individual patients a month over about 6000 visits monthly, and on average, the clinics in Athens see roughly 100 – 200 patients a month.

Between 2009 and 2011 there was a 14% decline in health spending seeing many services with curtailed hours or closing completely, and so such urban experiments were permitted by the state, seemingly as an attempt to deal with drastically cut services. The social clinics themselves are more than just a medical service, they are explicitly political. One volunteer, a retiree who did administrative records keeping at one clinic said:

> We are a political organisation in the sense of, not party politics, but in the sense that we're here to say that universal and cost-free public health for everybody is a right. It is not a privilege. And you'd better get your act together, State, and do it. Because we're not replacing the state. So, we're here to do a little shaming along those lines. (Interview, Volunteer, Solidarity Clinic, Athens, 2018)

The clinics have been successful in both providing an essential health service as well as pushing for policy change. For example, many solidarity clinics have negotiated space to operate within municipal buildings. In many instances, formerly vacant properties are provided rent-free, and the city pays for electricity and water so that the clinics can function outside of the national medical system. In other instances, the clinics and pharmacies are located within larger housing squats throughout the city (though the 2019 clearing of many squats also meant the closure of many of these spaces), and while they remain entirely independent of state support, they are listed resources by both the municipality of Athens as well as NGOs working with vulnerable communities.

The volunteers are not shy about their advocacy, as the quote above demonstrates. And while we cannot draw a clear line between their political work and legal changes, in 2015, the laws excluding the unemployed from public health insurance as well as the hiring freeze on medical professionals were lifted. Although Greece repealed laws harming the healthcare system, the damage to an already precarious system had been done and thus the need for the solidarity clinics has not lessened. In particular, the pharmacy services are in highest demand due to the 20 percent co-pay on medication, which most unemployed or marginally employed people cannot afford. Therefore, solidarity clinics continue to run in parallel to the public health system. The clinics have been an experiment in health service provision outside the state, and they provide a three-fold function. First the immediate bodily function of providing medical care to those in need. Second, they provide a social function, as a stop-gap to the crumbling social and state infrastructures, they are places of community and work also to provide connections with other services. And third, they provide a political outlet through which the structural violence of austerity can be articulated and resisted. Their acceptance within the healthcare system demonstrates how contentious public health interventions are becoming more and more a mainstay of current municipal politics in health and social care (Di Feliciantonio 2017; Di Feliciantonio and O'Callaghan 2020). Their acceptance in this case demonstrated through the provision of municipal land on which some operate.

Conclusion

I end with the Athens example as a hopeful one to demonstrate that analysing a globally mobile policy like austerity from a relational perspective, looking at the international institutions and actors involved in mobilizing policy ideas in connection with the places where these policies are enacted and experienced underscores the socio-spatial nature of policy. As McCann and Ward (2011) argue, as policies move through and are imparted into places, they change those places while also changing their own form, disturbing the narrative that policy mobility is a linear process, as these examples have shown. It highlights how thinking through crisis policy making as a formational political moment can point to more progressive practices and processes, such as solidarity networks, underscoring the need, as

Robinson (2015) argues, to examine not only the sites of best practice creation but also the cities where mobile policies 'touch down' and effect the material realities of urban lives.

Over two years into the Covid 19 Pandemic and crisis policy making in the wake of health and care continues to demonstrate the tensions between deepening inequalities and experimental political moves leading towards better health and social outcomes. For example, since the Covid 19 Pandemic, access to health services for people who use drugs in Budapest has largely remained the same, yet that access is still classified as one of the lowest in Europe. Once exception is that the terms of access to Opioid Substitution Therapy was relaxed during the first wave and has remained so since (Sarosi 2020). This policy decision taken in a moment of crisis has benefited people previously excluded from potentially life changing drug treatment, and is demonstrable of how mundane experimentation that crisis policy making can enact life-changing health regimes.

In crisis, hegemonic discourses such as neoliberalism are often reasserted, however this is not inevitable. Athina Arampatzi (2017), in her ethnographic work on solidarity economies, argues that solidarity as a concept has power in mobilizing local communities in forms of resistance. It is a cornerstone of survival infrastructure for marginalized communities. Shared hardship engenders shared action against austerity while also opening space for alternatives to emerge. Crisis policy making can and has contributed to a condition in which revanchist public health policies serve to worsen the health of some of the cities poorest and most marginalized, further disenfranchising people who might otherwise contribute to a vibrant resistance to austerity. However, understanding crisis policy making can also contribute to enacting policy ideas and practices that can subvert the seemingly steady march of neoliberal logics under austerity and produce progressive or even radical urban worlds.

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