Economic Recession and Mental Health: an Overview

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Effects of the current global economic downturn on population mental health will emerge in the years ahead. Judging from earlier experience of financial crises in various parts of the world, stresses associated with rising unemployment, poverty and social insecurity will lead to upward trends in many national suicide rates, as well as to less readily charted increase in the prevalence of psychiatric illness, alcohol-related disorders and illicit drug use. At the same time, mental health services are being cut back as part of government austerity programs. Budget cuts will thus affect psychiatric services adversely just when economic stressors are raising the levels of need and demand in affected populations.

Proactive fiscal and social policies could, however, help to mitigate the health consequences of recession. Evidence-based preventive measures include active labor market and family support programs, regulation of alcohol prices and availability, community care for known high-risk groups, and debt relief projects. Economic mental health care could best be achieved, not by decimating services but by planning and deploying these to meet the needs of defined area populations.

In 2008, a major economic crisis struck many developed industrial countries. By April 2009 the International Monetary Fund [8] estimated that banks and finance houses across the world had lost four trillion (4 x 10\(^{12}\)) US dollars in the value of their holdings. Growth in developing nations declined to only 2% per annum, or to zero if China and India were omitted. The World Bank[20] estimated a consequent rise of around 30 millions in global unemployment, mainly in developing countries, and an increase of from 55 to 90 millions in the ‘extreme poverty’ class of those subsisting on US$ 1.25 daily or less. Loss or slowdown of economic growth following on the crisis could result in an additional 200.000-400.000 infant deaths annually over the period 2009-15.

The global economic downturn and its consequences are thus of profound significance for the health and wellbeing of affected populations. Pro-aktive fiskalische und sozial-politische Maßnahmen können dazu beitragen, die negativen Gesundheitsfolgen des wirtschaftlichen Abschwungs abzumildern. Zu den vorbeugenden Maßnahmen gehören unter anderem arbeitsmarktpolitische Maßnahmen, budgetkürzungen werden also genau zu jener Zeit die psychiatrische Versorgung belasten, in welcher der Bedarf in den betroffenen Bevölkerungsgruppen ansteigt.

Wirtschaftskrise und psychische Gesundheit: eine Übersicht


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of populations, especially in low-income and transitional societies. As yet, however, there is too little information regarding the effects on mental health to assess the world-wide consequences for psychiatry, which will emerge only slowly in the years ahead. Yet some broad inferences can already be drawn if the recession itself is considered, not as some kind of ‘big bang’ singularity, from which a new universe is emerging, but rather as one phase in a continuing process. In medical terminology, what we are faced with today can best be understood as an acute exacerbation of a chronic condition. There is good evidence that, in many countries, labor markets were already shrinking, food prices rising and income inequality on the increase, long before this crisis broke. In Europe, for example, unemployment among young adults had been running at up to 20% even in the years of growth and prosperity. There is thus already a fund of information about the influence on population health, not only of major crises, but also of lesser fluctuations in trade and the world economic order more generally.

**Mortality and health statistics**

With regard to the wider background of mortality rates and general health, the picture is far from simple. The over-all effects of recession, it seems, are complex and sometimes even paradoxical [1]. While age-specific mortality followed a generally downward trend throughout the twentieth century, the decline slowed down in boom periods and speeded up again during slumps. In the developed industrial world, rates of death due to all causes may rise in times of economic growth and decline during recessions. This can occur because increase in causes of death positively associated with economic activity – e.g., road traffic accidents – more than outweighs the reduction in those causes associated with unemployment and indigence.

The public health impact, moreover, has varied from one economic slump to another [18]. In the Great Depression of 1929–1932, international trade fell by 50%; unemployment rose steeply and so did the numbers of homeless persons. Yet in the U.S., for example, mortality rates fell in those years by around 10%. On the other hand, following the break-up of the Soviet Union in 1991 a different pattern emerged in the new republics. In the resulting collapse, state-owned assets were virtually given away to anybody who could take them over, inflation soared and peoples’ savings were wiped out. In this instance, mortality rates rose by up to 20%, corresponding to around three million excess deaths. Responsibility for the disaster has been attributed to over-hasty restructuring of the national economies, combined with unhealthy life-styles in which almost one-quarter of all men could be defined as heavy episodic drinkers [15].

In low-income countries, economic growth generally promotes better health standards via improved quality of life and access to health care. Yet once a country’s mean income level rises above the $5 000-10 000 a year level, further progress in health will depend less and less on continuing growth; more and more on investment in public services and the way in which wealth is distributed across the population [1].

**Suicide and homicide rates**

When the focus is narrowed to suicide mortality, the pattern of associations becomes more clear-cut. Well before the current recession, levels of unemployment were known to be predictive for suicide frequencies in European countries. Over the 1970s and ‘80s, when median rates for suicide in young males increased by over 40%, annual rates for most countries were highly correlated with the previous year’s unemployment figures [16]. In a recent analysis of European Union data for the past 30 years, Stuckler and others [19] found that each 1% rise in unemployment was associated with an overall proportionate increase in suicide rates for under-65 year olds, as well as a somewhat smaller increase in homicide cases.

Similar trends were reported after the monetary crisis which hit the Asian ‘tiger’ economies in 1997, leading to currency devaluations and great loss of trade. Suicide deaths, which had been declining for some years, now rose sharply. As reported by Shu Sen Chang and others [2], male suicide rates in 1998 were higher than those for the preceding year by 39% in Japan, 44% in Hong Kong and 45% in South Korea, corresponding to a total of over 10,000 additional suicide deaths. Increases were smaller in Taiwan and Singapore, where the economic impact on populations was less severe.

Although epidemic violence, as in the recent growth of terrorist outrages, cannot be explained by economic stress alone, there is growing evidence of a positive association. Khan [13], for instance, has proposed that in Pakistan the socio-demographic profile of suicide bombers is similar to that of persons who kill only themselves: both groups being largely comprised of young people with a background of poverty, poor education, unemployment and lack of social support. Here again, the population will be at increasing risk once a nation’s economy starts to collapse.

**Mental illness and substance misuse**

This effect on suicide risk should perhaps be seen as the tip of a psychiatric iceberg. The specialist literature leads us to expect that each recession, at least as measured in terms of unemployment, will be accompanied by increase in mental health service utilisation and reported prevalence of depression, anxiety and alcohol-related disorders, the latter in turn being linked to levels of domestic violence. It has been noted that around three-quarters of all jobs lost in the U.S. since 2007 were held by
men, suggesting that a prolonged recession would raise the prevalence of depression among males, especially those in less skilled occupations[6]. Here, however, one should note that much of the epidemiological research on this topic has serious weaknesses. Urban ecological studies mainly rely on ‘second-hand’ data; that is to say, on administrative indices and service contact rates. Area prevalence surveys carry the advantage that they do supply ‘first hand’ data, but as a rule these will be valid for only short cross-sections in time. Lifetime prevalence estimates, on the other hand, will be of little relevance in trying to establish the health consequences of economic fluctuations. Fortunately, some light is now being thrown on this question by findings from longitudinal and cohort studies. In Canada, for example, serial health survey data could be compared with changing economic indicators over a 25-year period (1985 – 2009) [4]. One-year prevalence estimates for depression and anxiety, assessed using standardized methods, were found to have risen during economic downturns and then declined as the markets recovered. Studies of substance misuse point in the same direction. In the United States, a large-scale respondent survey of alcohol consumption over an 11-year period concluded that frequency of binge drinking, among employed persons as well as those out of work, increased strongly with economic downturn [5]. Compton and Gfroerer [3], analyzing data from the U.S. National Survey on Drug Use and Health, found that reported frequency of illicit drug use was twice as high among unemployed persons as for those in work. With the coming of the present recession, the estimated total of unemployed drug users rose from 1.3 to 2.5 million within the space of two years.

**Impact on mental health services**

For those with severe mental illness, specialist referral and treatment may be crucial in determining outcome. Today, however, there is growing evidence that budget cuts are affecting psychiatric services adversely at the same time that economic stressors are raising the levels of need and demand in affected populations. In the United States the National Alliance on Mental Illness, in a systematic check of public expenditure over the past four years, found that 32 states faced with budget deficits had stripped a total of $1.8 billion from their mental health services [22]. California, for example, slashed funding by 16% and Kentucky by a remarkable 47%. In Arizona, where an untreated mentally ill man ran amok early this year, killing six people and wounding 13 others, the state had cut mental health budgets by $57 million over the previous two years. Because virtually all U.S. Medicaid-funded mental health services are optional, states with continuing deficits are thought likely to cut down further on these facilities.

In Britain, where psychiatric admissions are now rising for the first time in five years, the National Health Service has to make £20 billion in ‘efficiency savings’ over the next four years, and this will entail the loss of an estimated 50,000 workers, including doctors and nurses, over that period [17]. Here also there are fears that mental health units will suffer disproportionately.

For low-income and transitional societies even small reductions in health service budgets may be very damaging. It is hard to see how Pakistan, for example, with an average of one psychiatrist for 640,000 population [7], could make efficiency savings in mental health. International disparities are now being exacerbated by a growing failure of recruitment to psychiatry in high-income countries[11] and a corresponding increase in the ‘brain-drain’ of psychiatrists from the developing world[10]; a trend likely to be exacerbated by the current recession.

**Mitigating the consequences of recession**

Government policy can modify the consequences of economic downturn for a nation’s mental health. Crucially, proactive fiscal policy will be called for to encourage trade, stimulate new growth and reinvigorate the labor market. In addition, however, the impact will be less severe in those countries which already have well-established social safety nets in place. A cited example is the contrast between Spain, where rising unemployment in the 1970s and 1980s was accompanied by a corresponding increase in suicide risk, and Sweden, whose own banking crisis in the 1990s likewise threw many people out of work, but where the suicide rate actually declined in that period. This marked difference has been ascribed to the protective effect of the Swedish welfare state [19].

Here, resources in five key areas of social policy are considered to be important [21].

- **Active labor market programs**
  Measures to keep or resettle workers in employment can reduce the harmful effects of recessions. Such programs cover publicly supported employment agencies, retraining courses and special projects for school leavers, the unemployed and disabled persons.

- **Family support programs**
  Families in low-income groups are especially vulnerable to cuts in health and education services. Support measures should include allowances for the care of children and other dependent persons, as well as statutory minimum wage scales which extend to part-time and casual workers.

- **Regulation of alcohol prices and availability**
  Cost-effective measures include control of the licensing and sale of alcohol. Increase in the tax levies on alcoholic beverages reduces consumption per capita and the associated public health risks, includ-
ing alcohol-related mental disorders [12].

- Community health care for high-risk groups
  Affordable primary health care provides the most expeditious pathway to treatment for the mentally ill, while at the same time shifting the focus onto early diagnosis and secondary prevention. Public health agencies should adapt their service provision to meet the health challenges of economic crisis.

- Debt relief programs
  Advice and help from non-profit agencies can support vulnerable groups who are under the stress of debt repayment at exorbitant interest rates. In Britain people thus mired in debt have two to three times the frequency of depression or psychosis, double that of alcohol dependence and four times that of drug dependence, compared to the general population [9].

Although in this field substantive cost-effectiveness or other evaluative studies are still few in number, evidence in favor of such programs is gradually accruing. Findings to date are most clear-cut with respect to suicide risk, which provides a sensitive monitor of population distress. Data from European Union (EU) countries indicate that rise in unemployment did not increase suicide risk where annual spending on welfare programs was above $190 a head [19]. The average association observed in these countries for a 1% rise in the unemployment rate among people under 65 years is a 0.8% rise in the suicide rate. Here, each additional US$100 per person spent annually on active labor market programs reduced this effect on the suicide rate by 0.4 percentage points, while each US$ 100 per person spent on family support reduced the corresponding effect by 0.2 percentage points.

Discussion

On the available evidence, some basic postulates can be derived which bear on the current recession’s significance for mental health.

1. In a globalised world, human health, including mental health, is more and more influenced by man’s economic activities and their consequences.

2. Economic downturns raise population levels of unemployment, poverty and distress, and this in turn tends to increase suicide rates and the prevalence of psychiatric disorders.

3. In general, the consequences will be most severe for poor developing countries and for the poorest groups in all societies.

4. The impact will be greatest where public hardship grows rapidly and social safety nets are lacking. Social support programs, on the other hand, can to some extent mitigate the mental health consequences of recession.

The implications for psychiatry and the related professions are far-reaching and extend well beyond the scope of psychiatric - or indeed of medical - competence. Here, epidemiological principles may nonetheless provide a useful starting point. They remind us that mental illness is a major public-health burden; that in the last analysis psychiatry must be seen as a public-health discipline and that mental health care could be more economically and effectively delivered if services were planned and deployed to meet the needs of defined area populations, a purpose for which population-based research will be essential.

The logistics teach, moreover, that advance in this direction will require mental health principles and methods to be more widely diffused throughout medical practice, preferably with the aid of regular clinical contacts through liaison and primary care psychiatry. Finally, experience underlines the growing importance of international networking and information exchange.

A promising instance of participatory research is the International Observatory on Mental Health Systems (IOMHS), reported by Minas [14]. Developments of this kind may be of real value if they can remain independent of national governments, the pharmaceutical industry and big corporations. Psychiatrists and other groups who are committed to the cause of public mental health may suffer from a degree of professional isolation in their own countries and can be greatly helped by the sense of solidarity afforded by internet contacts, information exchange and research collaboration with colleagues across the world.

References


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