Editorials

Unintended consequences of social and economic policies for population health: towards a more intentional approach

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Over the last decade there has been a growing interest in exploring the unanticipated health impacts of social and economic policies designed mainly to improve well-being, reduce discrimination, maintain family stability and improve mobility for disadvantaged populations. Since many of these policies are closely linked to the channels through which ‘social determinants’ may impact health, this is an intuitively appealing and in fact, compelling area of investigation. In addition, many evaluations of such policies have strong experimental elements, thereby avoiding some of the downfall of observational studies where selection undermines our ability to make causal inferences. However, these evaluations have not been without significant problems. I outline three reasons to conduct this work and another three challenges to the interpretability of results.

Rationale for evaluating health impacts of social and economic policies

A major rationale to evaluating social and economic policies in terms of population health is that it is likely that conditions which improve population health will have to be modified in the public policy arena. Action to change policies that prove to be harmful to health are as important as implementing those that are likely to have positive effects. Over and over again, we have learned that asking individuals to change behaviour in the absence of a supportive social and economic context is very hard. Few people change this way. Traditionally policies that change tobacco prices and consumption, occupational and environmental exposures have more substantial health impacts than asking individuals to stop smoking or to wear safety gear and avoid toxic exposures.

Policy makers don’t find it helpful for us to say poor people are sicker—or social isolation leads to health declines—they need a solution—or at least the suggestion for a promising solution to make policy. Epidemiologists have been helpful in monitoring and identifying health inequalities but could be even more effective if they evaluated potential solutions. Policy makers want reliable information on what kinds of policy changes actually lead to health improvements. If not, they cling to what they understand about the benefits of specific medical care policies.

Policies often have spillover effects making them much more cost effective than policy makers realize. These spillover effects mean that policies designed to relieve poverty may have health impacts or they may actually cross over to improve not only the health of direct beneficiaries but other family members. For instance, the Earned Income Tax Credit (EITC) in the USA is a refundable tax credit targeted at low-wage workers. A striking study by Strully et al. shows that this credit increases single mother’s odds of working and both increases birth weights in their infants and reduces maternal smoking. In another study by Duflo et al., pensions available to older women in South Africa had cross over effects on their granddaughters. Young girls living with their grandmothers as they started to receive pensions were healthier than those living in the same family circumstances before the pension. We are currently engaged in a study to see if increasing work place flexibility will improve health of employees and their families. A range of related family policies have been linked to child health outcomes. If such spillover effects are common, it means we are regularly underestimating the cost-benefit of such policies. Furthermore, many of the spillover effects are intergenerational in impact. Positive intergenerational impacts may help to reduce resistance to policies that are seen as favouring one group e.g. older workers, families, recent immigrants.

The challenges

Observing changes in health in relation to the implementation of social and economic policies is not easy. In many cases, the period of exposure may not coincide with the most sensitive etiologic period for a large number of people. For example, environmental policies aimed at reducing lead exposure or pollution may have relatively strong effects on the very young or very old and weak effects overall if all age groups are examined. Also some health benefits may take years, if not decades to appear. Educational reforms may have impacts on cognitive function not evident until old age. Since, these studies have rarely been designed a priori; we often lack health indicators and biomarkers of risk that would be the most sensitive indicators of impact.

When one policy is implemented, others often co-exist. Attributing effects to one single policy may be harder than we think. While policy implementations substantially reduce selection effects, they do not solve the problem of what precisely the causal exposure is. For example, the EITC may be implemented in US states at the same time states are increasing Medicare benefits or implementing other anti poverty programmes. In Europe, family policies often simultaneously changed working conditions, day care and financial incentives. Approaches which hold place constant (some econometric approaches or time varying analyses) help to overcome some of this concern, but clearly more thought needs to go into understanding the confluence of policies which happen close in time and place.

Multiple channels are likely to mediate policy impacts on population health. These channels may be behavioural, social...
European mental health policy: the key issue is social inclusion

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The challenge of social exclusion

The paper by Fears and Horsch in this issue of the Journal sets out a clear approach to developing a mental health policy strategy for the EU, one that is subtly complemented by the thoughtful commentary by Wahlbeck. Yet there is an important wider context that must be considered at the same time: the need to promote the social inclusion of people with mental illness throughout Europe.

It is clear that many people with mental illness, in every country where this has been assessed, report profound experiences of social marginalization and exclusion1 (Supplementary references 1 and 2). A frequent domain for such discrimination is in relation to employment (Supplementary reference 3), but adverse experiences are also common for family relations, personal relationships and exclusion from social and leisure opportunities (Supplementary reference 4). It is therefore clear, as Fear and Horsch state, that a concerted approach across Europe to attacking stigma is now timely. Fortunately, evidence is now emerging that such anti-stigma initiatives can be effective, for example, drawing upon experiences in Germany (Supplementary reference 5), Scotland (Supplementary reference 6), England (Supplementary references 7 and 8) and the World Psychiatric Association Open the Doors programme (Supplementary reference 9).

Low levels of help seeking

One serious consequence of stigma is the low level of help seeking among people with mental illness. Despite the high numbers of the general population who could be diagnosed with a mental illness, only a minority actually seek professional help for these problems2 (Supplementary references 10 and 11), in an attempt to minimize personal reputational damage from being known to have consulted a mental health specialist. The consequences of failure to seek help include a continuation and perhaps worsening of symptoms and the continuation of stigma (Supplementary reference 12). Such views are common throughout Europe (Supplementary reference 13). For example a survey of over 12,000 individuals in several European countries have discovered that such views associated with treatment avoidance are supported by many or people in: Austria (29%), Germany (80%), Greece (81%), Poland (50%), Slovakia (61%) and Turkey (39%) (Supplementary reference 14).

Narrowing the mental health gap

In part for reasons of treatment avoidance, and in part because health policies in most EU Member States have attached a low priority to investment in mental health services3 (Supplementary references 15–17), most people in Europe world who have mental illnesses receive no effective treatment. More specifically, across the EU the proportion of people with diagnosable mental disorders who receive health-care interventions (‘coverage’) between 27% and 30.5% across the Europe2 (Supplementary references 11 and 18). Table 1 demonstrates the remarkable fact that the proportion of cases of mental illness in Europe which are treated is lower than that for physical illnesses in low-income countries, a clear indication of inequity (Supplementary reference 19).

In this context it is informative to consider that the 2011 World Bank categories indicate that within the WHO Europe and Central Asia Region, the low-income countries are: Kyrgyz Republic and Tajikistan; the lower middle-income countries are: Armenia, Georgia, Kosovo, Moldova, Turkmenistan, Ukraine and Uzbekistan; while the upper middle-income states are: Albania, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Kazakhstan, Latvia, Lithuania, Macedonia FYR, Montenegro,