Editorial
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Consequences of major economic crises on citizens' physical and mental health

Psychiatriki 2012, 23:105–108

There have been three major international economic crises during the twentieth century. The great depression, the so-called "financial crash" in 1929, the Russian and Baltic countries economic crisis in 1990 and the East and South-East Asian financial crisis in 1997.

During the "financial crash" there was a fall in international trade of more than 50%, most banks collapsed and unemployment rose rapidly. US policy-markers to mitigate the effects of the depression created a welfare system and invested in public health programs. The package implemented included relief of the unemployment, impoverished farmers, reform of financial regulation and support of wages and prices. Surprisingly, there was evidence that overall mortality in US urban populations fell during the crisis. Especially, there were reductions in mortality from infection diseases (pneumonia, tuberculosis) but concurrently increases in deaths from chronic diseases (heart diseases, cancer, diabetes) and suicide. However, according to recent retrospective epidemiological data, only heart diseases and suicide rate could possibly be directly linked to short-term economic shocks.[1,2]

In 1992, the Russian government started an economic program well known as "shock therapy". Abolition of price control resulted in soaring consumer prices, a rapid decrease in real wages and pensions, a loss of personal savings and a high increase in poverty rate. The next years life expectancy declined by 6 years in men and by 3 years in women. The main causes of death were diseases of the circulatory system and external/violent causes (i.e. suicide, accidents, injury and poisoning). Two principal explanations were proposed for the Russian mortality: stressful socio-economic conditions and heavy alcohol consumption.[3,4]

Baltic countries (Latvia, Estonia, Lithuania) experienced dramatic social-economic upheaval during the same time period. The independence movement of these new states and the rapid transformation of the societies lead to the lost of the State which had taken care for the citizens. There was a rapid increase in poverty, unemployment, divorce rates, general mortality rates and especially suicide. The social changes primarily affected males because of their traditional role to take care of the family's wellbeing and to earn money.[1,3]

In 1997, economic crisis began in Thailand and quickly spread to neighboring economies including Philippines, South Korea, Japan, India, Malaysia and Indonesia. There was an increase in general mortality and especially from suicide in most of the countries. Epidemiological studies conducted suggest that mortality rates were, mainly, associated with the rapid increase in unemployment and decline in household income. It is worth to note that Singapore and Taiwan were less affected by the crisis. This was attributed to the smallest impact of crisis on GDP and unemployment rates.[3–5]

The European economic crisis started in 2008 and has mainly affected the Greek population.[6] Unemployment has risen from 6.6% in 2008 to 22% in 2012 while youth unemployment rose to 45%. Greek Government borrowed from the International Monetary Fund and Eurozone partners under strict conditions that included drastic curtailing of government spendings. As a result, there were cuts in public hospital beds, cuts in health workers and generally in health care spending. In spite of these conditions, an increase in admissions in public hospitals and a decrease in

admissions in private hospitals was recorded. Yet, according to recent data there was an increase in suicide and in attempted suicide, in violence and homicide, in HIV infected people and in heroin users was observed.[7–9]

What can we learn from the experience of the aforementioned economic crises? The main conclusion is that the health impact of the crisis may depend mainly on the dept and length of the crisis and the buffering capacity of a society. Under condition of economic crisis the unemployed, the poor as well as individuals already experiencing a chronic physical or mental disease represent high risk groups for morbidity/mortality or suicide behaviors. In hard times of economic-social crises, the first priority of countries should be the protection of high risk individuals.[1,4,10]

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