

Letters to the Editor

Suicides, hurricanes and economic crisis

Director,

Lopez Bernal *et al.*¹ detected a suicide rate trend, between 2005 and 2010, of a 0.3% decrease per month and, above this underlying trend, an 8% increase in Spanish suicide rates since the financial crisis using an interrupted time-series analysis.

However, their model considers the economic crisis as an event that occurred suddenly in March 2008, so there is a 'before' and an 'after' that date with regard to monthly suicide rates. The authors decided that 1 April 2008 is the precise date of the 'economic hurricane' in Spain.

According to the most usual definition of economic recession (two consecutive quarters of decline in a country's real gross domestic product calculated as annual rate of change), the aftermath of the economic crisis in Spain was not in the second quarter of 2008, but at the first quarter of 2009.

By the summer of 2008, the provisions of gross domestic product growth were still positive. Neither the central nor regional governments had started any restrictions in social policies or social protection. Public budgets increased in 2008 as in the previous years. Neither the public expenditure on social protection nor in the healthcare system has fallen substantially until 2010/2011.

The authors have addressed the problem of the definition of the crisis with a

sensitivity analysis in which, first, they set an even further away starting point: July 2007 (8% unemployment rate), with strikingly similar results (8% increase over the underlying trend); and, second, they set a final time of crisis: December 2009 (20% unemployment) and find a trend downshift.

Furthermore, and from the official statistics, yearly rates of mortality for suicide in Spain from 2006 to 2011 have been declining, with the exception of the specific increase of 6.9% between 2007 and 2008 for men and 2010 and 2011 for women. Particularly in 2010, the decrease has been noticeable. The fact that 2008 shows a transitory one-time increase in the suicides rates in men could explain the results reported.

The authors suggest that one of the main reasons behind the suicide patterns would be unemployment. In fact, economic crisis in Spain is characterized by high rates of unemployment. As monthly unemployment and mortality data are available (at least since 1998), it would be worth it to model a dynamic causal model. In fact, some of the authors are experts in those models,² and they have previously operationalized economic recession in the unemployment rate and quantified its association with suicides rates.³

The long-term decreasing trend of suicide rates in Spain is well established with time series up to 2008.⁴ The question is if there has been a discontinuity in the series due to the economic crisis. The article suggests a positive answer. Instead, we have argued that the association between economic crisis and suicide mortality in Spain is far

from being proven. One should be cautious and avoid getting alarmed by early warning that, even through they could be good for protecting health budgets from menacing cuts, do not reflect the measurable facts.

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RE: The effect of the late 2000s financial crisis on suicides in Spain: an interrupted time-series analysis

Dear Editor,

In their letter, Librero *et al.* have highlighted one of the main issues affecting studies of the financial crisis (and one that we highlighted ourselves in the 'Strengths and Limitations' section of the original article), that is, 'how do we define the financial crisis?'. As recommended when undertaking

interrupted time series analyses of imperfectly identifiable events, we do this as objectively as possible by using an independent indicator—in this case gross domestic product (GDP).¹ This is the most commonly used indicator to define a financial crisis; we use it in the same way as in similar studies. There is considerable debate among economists as to how to define a recession, but we used the most widely used definition 'a decline in the seasonally and calendar adjusted real GDP in at least two successive quarters'.² According to Organisation for Economic Co-operation and Development figures,

there were seven successive quarters of decline in GDP in Spain between the second quarter of 2008 and the last quarter of 2009 (Web Appendix 1 of the original article).

Librero *et al.* suggest that we should have used a later date for the onset of the financial crisis given that the government had not yet cut social spending. However, as we have noted elsewhere, the health effects of financial crises are often apparent before changes in economic indicators, reflecting high levels of apprehension at already visible impending difficulties.³ The financial crisis was clearly having an impact on people's lives even before GDP started to

decline given that unemployment was already starting to increase in 2007, and it is stressors such as those arising from job loss that contribute to poor mental well-being.⁴ It was for this reason that, in our sensitivity analysis, we tested the effect of the crisis starting in July 2007, based on unemployment. In fact, this did yield a similar result to the main model (although not exactly the same as Librero et al. seem to suggest by rounding them both up to 8%).

We are not clear what Librero et al. meant by stating that we ‘set a final time of crisis: December 2009 (20% unemployment)’ in the other sensitivity analysis, as this model was based on GDP (and the temporary increase in 2010) and not unemployment.

We agree with Librero et al. that further research should model the association between unemployment and suicide, although, as we highlight in the original article, this has already been investigated extensively and there is a well-documented association between the two.⁵ The aim of our study was, however, to establish whether there was an increase in suicides in Spain in this financial crisis, rather than to

investigate the effect of one particular manifestation of the crisis.

We also agree that the associations we describe cannot be considered as definitively causal as with any observational study. In fact, in the opening sentence of our ‘Interpretation and Implications’ section, we state that ‘Our study alone cannot establish whether the association found between the financial crisis and suicides is causal’. Nevertheless, we disagree that one should resist publishing alarming results; publication should not be based on the results that are found but rather the importance of the question and the merit of the study. Irrespective of whether these results are alarming, they should be used to aid informed decisions that maximize public health and well-being.

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The realisation of a European health information system—time to get the politicians involved

The 2013 European Public Health Conference (EPHC) in Brussels brought together representatives of the European Commission’s (EC) Directorate General for Health and Consumers (DG SANCO), the European Regional Office of the World Health Organization (WHO-EUR), the Organisation for Economic Co-operation and Development (OECD) and EUPHA. The aim of the round table discussion was to explore how the diverse European health information initiatives could be integrated to create an infrastructure that is comprehensive, functional and sustainable.

So far, the EC has given financial support to projects to develop common European instruments for health interviews and examinations and the development of health indicators. However, despite many individual successes, these have yet to translate into an integrated system that

enables policymakers, researchers and citizens to obtain a comprehensive, timely and consistent picture of the health of Europe’s population. This suggests a lack of vision and commitment by Europe’s leaders, a view that has been communicated to Commissioner Borg by the European public health community.¹ As long ago as 2010, the EC and WHO, since joined by OECD, agreed a roadmap towards a single European Health Information System. Despite several individual initiatives, concrete action has so far been lacking.

Those present in Brussels examined the possibilities to develop such a system under the current EU health mandate. Article 168 (2) of the EU Treaty states that ‘...The Commission may, in close contact with Member States, take any useful initiative to promote [...] the preparation of the necessary elements for periodic monitoring and evaluation.’² yet the EC does not seem to have taken the opportunity available to it. This is despite the clearly stated intention of all its Member States, enshrined in their support for WHO EURO’s Health 2020 policy, which requires monitoring of agreed health targets, a task that should be

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incorporated in a single monitoring system.³ Yet, these words have not been matched by action.

Policy making on EU level can follow two political routes.⁴ The low politics route, in which action is initiated by professional concern and developed by expert groups, has been tried for many years but has failed. This suggests that it is now time to pursue the high politics route, in which action is initiated by political leaders. Of course politicians need to be convinced by us, the public health community. But if we believe that information about the health of our fellow citizens is needed to achieve transparent and cost-effective policies, we have a duty to formulate a strong case that can convince our national politicians to take action in the institutions of the EU and WHO. Together we can achieve a new health agenda for Europe⁵ underpinned by timely and accurate health information.

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