antidepressants, has increased. This area merits further study, not least because the apparent increase in suicide following Ireland's economic problems emerged only in 2011, some years after Ireland's economic problems commenced. Extrapolating from this trend, there may well be similar increases in presentations with depression and anxiety disorders in primary care in future years (McElwee, 2009).

Finally, self-rated happiness in Ireland has declined significantly. The increasingly close association between happiness and income, as opposed to health, between 2005 and 2009 likely reflected the effects of Ireland's economic problems on employment rates and income. The more recent finding that happiness no longer demonstrates independent relationships with *any* of its traditional predictors may reflect the transitional situation in which Ireland finds itself, as the economy stabilises and Ireland finds its feet in a new and altered economic world.

Alternatively, the absence of any robust, independent predictors of happiness at this time may simply reflect the idea that happiness, in the end, can be neither fully explained nor purposively sought. Perhaps, in words commonly attributed to American philosopher Henry David Thoreau (1817–62), 'happiness is like a butterfly: the more you chase it, the more it will elude you, but if you turn your attention to other things, it will come and sit softly on your shoulder'.

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THEMATIC PAPER

ECONOMIC CRISES AND MENTAL HEALTH

Mental health impact of the economic crisis in Spain

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According to preliminary data, by 2010 the economic crisis in Spain had already led to an increase in the prevalence of anxiety, mood disorders and alcohol misuse, identified in primary care settings, but there had not been an impact on suicide rates. Since then, several indicators suggest that the full impact of the economic crisis on mental health was delayed, until at least the second half of 2011 and even later, to 2012. There is increasing evidence that budget cuts had a particular impact on mental healthcare during this latter period.

After a decade of high growth, the Spanish economy was beginning to contract by the end of 2007. Spanish debt grew from 12% of gross domestic product (GDP) in 2009 to over 90% of GDP in 2012, while government revenues plummeted. With increasing unemployment, the social security system lost nearly 3 million contributors after 2008 and this had caused a €6.5 billion deficit in the pension system by 2012, according to data from the website of the Instituto Nacional de Estadistica (INE; http://www.ine.es). The Spanish government did not institute any intervention strategies to deal with the financial crisis until mid-2011. The main impact of the financial crisis on Spanish citizens was therefore delayed until late 2011, partly because of the buffer effect of a highly developed social support network, and partly because of a contentious government strategy which allowed the national debt to increase in order to support welfare benefits and social protection, as well as to allow the provision of aid to local governments, companies and others. Hence,

comprehensive data on the period 2011–13 will be necessary in order fully to understand the impact of the financial crisis on mental health in Spain.

Social and demographic characteristics

The national unemployment rate increased from 8.6% in 2006 to 25% in October 2012. Spanish youth unemployment is now over 51% and it is particularly high for those who have not completed full-time education; as many as one in three students do not complete upper secondary education in Spain, according to the United Nations Educational, Scientific and Cultural Organization (2012, p. 17). The impact on mental health is attributable not only to the precariousness of employment and to unemployment, but extends far beyond the actual loss of one's job (e.g. anticipation of unemployment and insecurity among family members and in the broader social network) (Vives *et al*, 2011; Gili *et al*, 2012).

In 2010, the proportion of people living in conditions of extreme poverty was 5.3%, and by 2012 evictions had increased by 134% (126 426 cases). The number of registered homeless persons who have used any social service nearly doubled between 2008 (11 844 persons) and 2012 (22 938). Of these homeless people, 32% had lost their homes during the previous year (INE website).

Up until 2012, families were a major buffer that limited the impact of social deprivation, mainly by providing financial support and shelter. By November 2012, 300 000 households depended exclusively on the retirement pension received by one member of the family. Over half (52.8%) of people aged between 18 and 34 years lived with their parents. Unfortunately, this buffer effect cannot be sustained, because of the persistence of the crisis. By the end of 2012, the number of families with all members unemployed was over 1.73 million; and 4.46 million of the 17 million Spanish households did not have an economically active member in October 2012 (INE website).

Impact of the economic crisis on psychiatric morbidity and mortality

The 2011 report on National Health System Key Indicators from the Ministerio de Sanidad, Servicios Sociales e Igualdad (Ministry of Health, Social Policy and Equality) (MHSPE, 2012) and the European Study of the Epidemiology of Mental Disorders (ESEMeD study) (Alonso *et al*, 2004) indicate prevalence rates of mental disorders in Spain that are similar to those found in Italy but lower than those seen in northern European countries. A recent survey on the prevalence of mental disorders treated in primary care during 2006–07 and 2010–11 revealed substantial increases in the proportion of patients with major depression and other mood disorders, generalised anxiety disorder, panic disorder, somatoform and alcohol-related disorders. The authors observed a particularly high risk of major depression associated with mortgage repayment difficulties and evictions. These events accounted for about one-third of the overall risk in the consulting population's attendance with mental health disorders. Mortgage payment difficulties accounted for an additional 11.0% of the overall population risk of depression among primary care attendees (Gili *et al*, 2012).

Rates of suicide showed a slight increase during the recessions that occurred between 1980 and 1996 (Tapia Granados, 2005) and then remained constant from 1996 until 2007 (Gotsens *et al*, 2012). In 2009 Spain had the third lowest European rate of suicide in men, after Greece and Italy. In 2010 registered suicides were actually lower than in 2008 (3145 *v.* 3421 cases). The age-adjusted mortality rate due to suicide and self-injury (per 100 000 population) was 6.3 in Spain in 2009, and became slightly lower in 2010 (INE website). The reduction in the suicide rate in Spain between 2007 and 2010 is in contrast to the increasing suicide rate reported from other European countries, apparently related to the financial crisis (Barr *et al*, 2012). There does not seem to be a direct relationship between unemployment and suicide in Spain. However, data from the period 2011 to 2013 may provide a different picture, because there could be a delayed impact of the financial crisis.

Impact on the general healthcare system and health financing

Total health spending accounted for 9.6% of GDP in Spain in 2009, which is slightly higher than the average for the Organisation for Economic Co-operation and Development (OECD). There was an increase in the proportion of government expenditure on health during the period 2009 to 2011, although this figure is misleading. There was a sharp reduction in Spanish GDP after 2008, while health expenditure was kept at the previous level (€100 billion in 2009) until 2012 (OECD, 2012). Sustaining health expenditure in the face of decreasing GDP was achieved by increasing the structural financial debt of the National Health Service (NHS), which tripled from 2005 (€5 billion) to 2011 (€16 billion). The government approved health reform measures in April 2012 in order to deal with a pending crisis in the national health system. These reforms included introducing co-payment for pharmaceuticals and certain health products, a reduction in the overall health budget of €7 billion, repayment of debts totalling €12 billion to healthcare providers and a series of cost-containment measures that were addressed to non-resident users of the Spanish NHS.

The financial crisis has had impacts of different intensity on the 17 regional health systems in Spain. Regions have developed different strategies to deal with the problem. In Catalonia, there was a decrease in the use of out-patient care in the community mental health centres in 2011 and again in 2012. This reduction may be related to budget cuts in the provision of specialised mental healthcare. In 2012 there was a 2% reduction in the tariffs for mental healthcare, a 5% reduction of the activity of specialised mental healthcare and a 10% cut in the

budget of community mental health centres. Care delivery contracts were reduced by 7% and specific mental care programmes by 8%; for example, a support programme to provide independent living for persons with severe mental illness living alone was discontinued in 2012 (Catalan Association of Families and Users with Mental Illness, 2012).

Cuts in government healthcare expenditure were greatest in pharmaceuticals and staff costs. In 2010, 18.9% of total health expenditure in Spain was on pharmaceuticals (OECD, 2012). The cost of drugs as a proportion of total direct expenditure on health was higher for mental disorders than for other conditions (e.g. accounting for 65% of direct costs of depression in Catalonia) (Salvador-Carulla *et al*, 2011). In July 2012 a new patient co-payment system was introduced. The degree of co-payment was means tested and depended on the patient's income, with some exceptions. A reduction in the NHS listing of approved pharmaceuticals was introduced a month later. These two measures have had a major impact, leading to a reduction in expenditure on pharmaceutical products: a 17.8% reduction in the annual expenditure on pharmaceuticals was achieved by October 2012, and the figure is above 22% since the introduction of co-payment. The total saving on drug expenditure in 2012 was over €1.2 billion (€931 million in the last 5 months of 2012) while prescriptions decreased 13.6% in November 2012. Prior to these new measures, consumption of antidepressants and anxiolytics had grown by 12.6% between 2007 and 2011.

Social care

The 2012 budget cuts have had a significant impact on provisions made by the social care system for people with disabilities, particularly in severe cases of functional dependency, the costs of which are covered by the regional agencies. Royal Decree 20/2012, dated 13 July 2012, aimed to bring about a reduction in the social care budget of €1.59 billion, which would have a major effect on the functional dependency care subsystem. New regulations have restricted eligibility to severe cases. Provisions for those with moderate functional dependency (which includes most severe mental illness) have been delayed until 2015; benefits for families providing care have been reduced by 15%. Deductions for employers already providing contracts to persons with disabilities have been reduced from 70% to 50% and new contracts to support such employment have been discontinued (Catalan Association of Families and Users with Mental Illness, 2012).

Conclusions

The abrupt collapse of the Spanish economy has created conditions of economic hardship for many people. There has been an increase in taxation, associated with a sharp fall in tax revenue and investment, and rising national debt. This situation poses a huge challenge to the Spanish welfare system and especially to the health and social care sectors. Uncertainties about continuing employment prospects, increasing unemployment and widespread mortgage payment difficulties have had a cumulative deleterious impact on mental health, especially on rates of affective disorders and alcohol misuse (Gili *et al*, 2012). In addition, Spain is particularly vulnerable to other risk determinants of poor mental health, such as the high proportion of students who do not complete secondary education. These issues may prolong the long-term consequences of the crisis.

In summary, the economic crisis in Spain may have a significant but delayed impact on mental health. Already, the provision of mental healthcare has decreased sharply during the past 2 years. Both national and regional action plans should incorporate measures to reduce the short-term and the long-term consequences of the economic crisis. Recommendations suggested by experts from other European countries (Wahlbeck & McDaid, 2012) may contribute to the appropriate design of action plans to mitigate the impact of the crisis.

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