

Is the Recession Making Us Sick?

BY SARAH BURGARD

Are we experiencing a “health recession”? While many think the impacts of the Great Recession are mostly confined to the labor and housing markets, the recession may also have taken a toll on health and well-being. In assessing such health impacts, it’s important to distinguish between direct and indirect effects, the former pertaining to the health of those who are directly impacted by recession-induced negative events, such as unemployment, and the latter pertaining to the more diffuse behavioral changes that a recession may bring about among the general population. For example, the recession might reduce the amount of discretionary driving (to save on fuel costs), with the indirect result being fewer accidents.

We expect direct effects, by contrast, to be mainly of the negative variety. These direct effects of the recession are health-harming because of the stress and material hardship experienced by individuals who go through foreclosures, job losses, extended unemployment, and financial strain. For example, research by Kate Strully, William Gallo, and others has found that those who lose jobs have a substantially greater chance of developing a new health problem, while Till von Wachter and Daniel Sullivan have found that job displacements are associated with a higher risk of mortality for men even a decade after the displacement occurs. A recent study by Craig Pollack and Julia Lynch showed that those undergoing foreclosure are more likely to experience deteriorating health, a result that's consistent with a larger literature showing that housing insecurity may lead to declining health.

However, while recessionary events appear to harm the health of those who experience them, many individuals do not directly suffer these shocks—even during a harsh economic downturn. This helps to explain why other research, such as a recent study by Christopher Ruhm, finds that, by some measures, health may actually improve during economic downturns. The indirect effects of the recession are often health-improving and thus operate to counteract the health-harming direct effects.

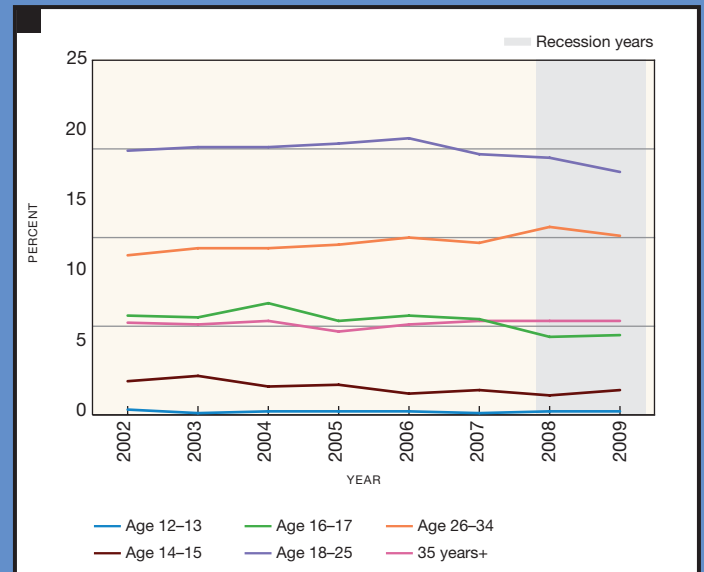
There are various ways in which such indirect effects can be health-improving. For example, there is less disposable income during a recession for unhealthy snacks or substances, for eating out (which tends to be unhealthful), or for discretionary driving (which increases pollution and the risk of auto accidents). Because the demand for labor weakens in a recession, people will also work fewer hours on average, thus reducing the chances of on-the-job injuries and increasing time for activities that enhance well-being. At the aggregate level, these types of behavioral changes can make the population healthier.

The potentially offsetting effects of such direct and indirect processes can explain why, at the aggregate level, some health outcomes deteriorate and others improve in a recession. The key variables in this regard are (a) the proportion of the population that experiences a direct recession event (e.g., unemployment), (b) the extent to which such experiences have health-harming direct effects (for the outcome in question), and (c) the extent to which the indirect behavioral changes among the general population are health-improving. These three variables may combine in different ways for different health outcomes and thus yield different trends.

The purpose of this article is to summarize these aggregate trends. We pose the following questions: Is the recession lowering the aggregate level of physical well-being in the U.S.? Is it lowering the aggregate level of mental well-being? How has access to health care changed, if at all, with the recession?

In the course of addressing these three questions, we will bear in mind (a) the distinction between direct and indirect effects, and (b) the equally important distinction between short-run and possible long-run (and hence as yet undetected) effects.

FIGURE 1. Heavy alcohol use in the past month among persons 12 years of age and older by age group, 2002–2009



Source: Health, United States 2010. <http://www.cdc.gov/nchs/hus/contents2010.htm>

We will also consider whether trends in aggregate health indicators are similar across social groups defined by age, gender, and race or ethnicity.

Aggregate Trends in Health

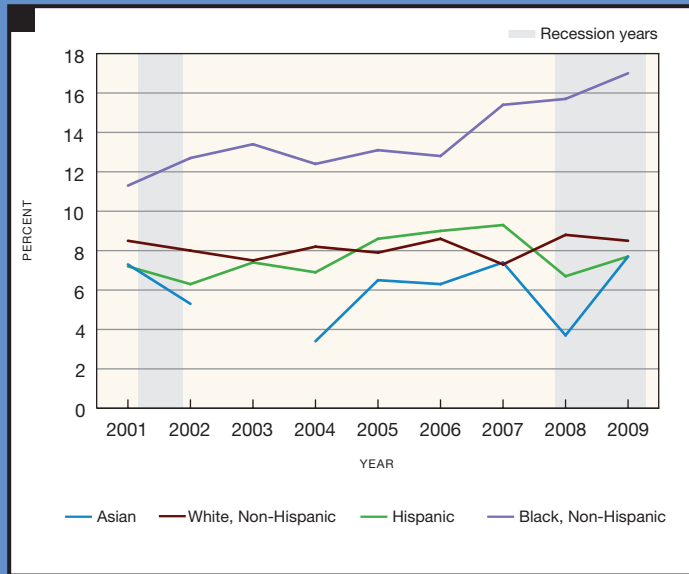
We begin by considering aggregate trends in the physical health of the U.S. population. The good news here is that, when considering the U.S. population as a whole, we do not see troubling changes in several key measures of health. Trends of slowly rising life expectancy and declining infant mortality have continued undisturbed, and there are no sharp changes in the fraction of infants with low birth weights.

Likewise, data on various health behaviors are encouraging, with trends either holding steady or turning in a slightly healthier direction in recent years. The percentage of Americans who are overweight continues to increase, but not at any faster rate since the recession began, while rates of obesity have not changed, and rates of tobacco use have remained similar to pre-recession levels or declined slightly.

As an example of this “no effects” conclusion, we’ve presented in figure 1 trends in rates of heavy drinking, a result of interest because many commentators hypothesized that Americans would “turn to drink” in the recession. To the contrary, figure 1 shows that rates of heavy drinking are, since 2006, unchanged or slightly declining across all age groups. This result could of course arise because any increases in the motivation to drink (e.g., enhanced stress) are counterbalanced by the decline in resources to purchase alcohol.

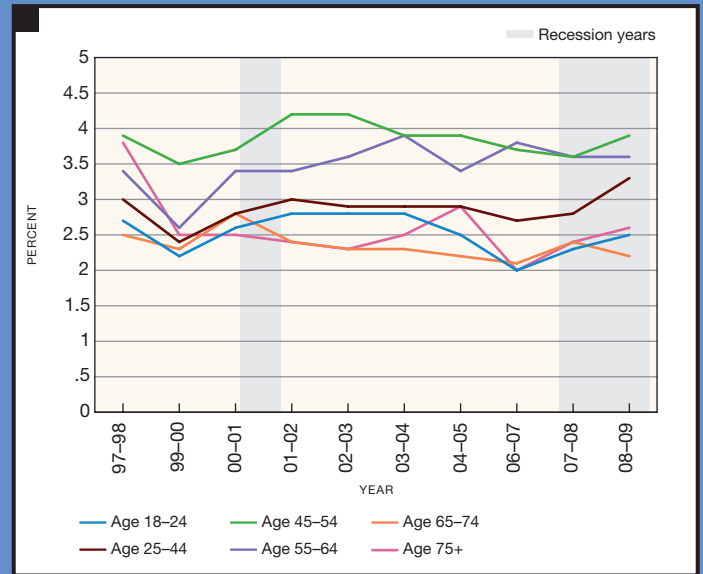
Although the initial evidence is therefore largely encourag-

FIGURE 2. Percentage of children who currently have asthma by race and Hispanic origin, 2001–2009



Source: childstats.gov. <http://www.childstats.gov/americaschildren/tables/health8b.asp?popup=true>

FIGURE 3. Percentage of adults reporting serious psychological distress in the past 30 days by age group, 1997/98–2008/09



Source: <http://www.cdc.gov/nchs/hus/contents2010.htm>

ing, there are at least three reasons to be cautious and to withhold any final judgement. Most obviously, we don't always have good post-recession data for key indicators. The trend data for suicide, for example, have only just been analyzed and suggest more troubling health consequences of the Great Recession. Second, it's also possible that many of the negative effects, especially those that are linked to exposure to stress, may take some time to register and may be concealed within time series that, at this point, can only speak to immediate effects. The direct effects of the sort discussed in our introductory comments are precisely of this sort.

The third and most important reason to withhold judgment is that a few measures of health suggest, even at this early point, a negative recession effect on health. We provide one such example in figure 2. As shown here, African American children suffer from asthma at a higher rate than children from other racial or ethnic groups. More relevant to our purposes, we also see that African American children experienced a small increase in asthma following the recession, as did Asians and Hispanics. Although the sharpest uptick for African Americans occurs prior to the recession, we also see an additional uptick during the recession itself.

Aggregate Trends in Mental Health

But what about mental health problems? If the recession is viewed as a stress-increasing event, it's possible that most of its effects on health will register in the mental health domain. Although recession-based stress will be most extreme among those who directly experience negative events (e.g., unemployment, negative equity, foreclosure), the baseline probability of experiencing nega-

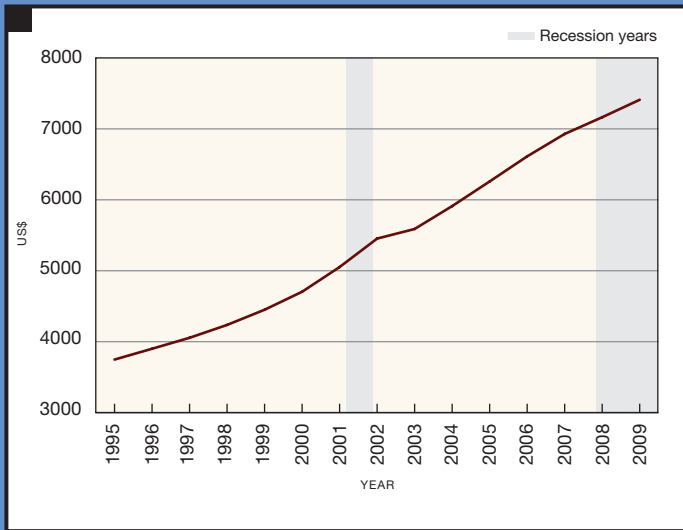
tive events is so high in the ongoing downturn that, even for those who haven't directly experienced them, there's still good reason to worry about experiencing them in the future. This line of reasoning suggests that the mental health effects of the recession may be detectable even now.

There is some suggestive evidence in support of just such an account. Figure 3, which reports levels of serious psychological distress, shows an uptick among several age groups. For 25 to 44 year olds, the rate of serious distress in 2008–2009 was 3.3 percent, compared to 3 percent or less between 1997 and 2008. It bears noting that this group, especially at the younger end of the age range, has faced the most employment and housing instability related to the recession. Although the increase in distress is not all that large, it's relevant that it's happening across various vulnerable age groups.

Again, it's wise to counsel caution in interpreting these results, just as we did in presenting the more negative results of the prior section. Why be cautious? First, other data suggest that, at least among children, levels of reported emotional problems have not changed much recently. It's possible that distressed parents can buffer their children against any negative effects (at least in the short run). Second, research conducted before the Great Recession by Sidra Goldman-Meller and colleagues found only limited support for a link between recessions and depressive symptoms, again at the population level.

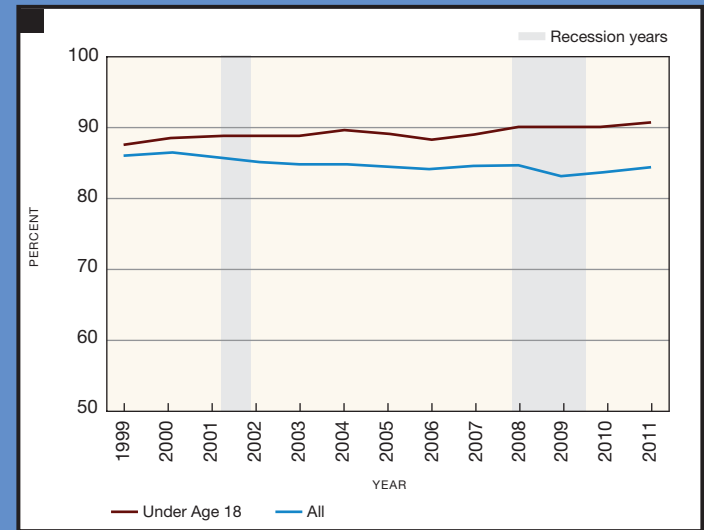
It's accordingly too early to reach any definitive conclusions. The trends we present here are nonetheless worrying and suggest the importance of continued monitoring and assessment of other measures of mental health as they become available.

FIGURE 4. Health expenditures per capita in the United States in current U.S. dollars, 1995–2009



Source: <http://data.worldbank.org/indicator/SH.XPD.PCAP>

FIGURE 5. Percentage with health insurance coverage in the United States overall and among children, 1999–2011



Source: U.S. Census Bureau.



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work fewer hours on average, thus reducing the chances of on-the-job injuries and increasing time for activities that enhance well-being. At the aggregate level, these types of behavioral changes can make the population healthier.

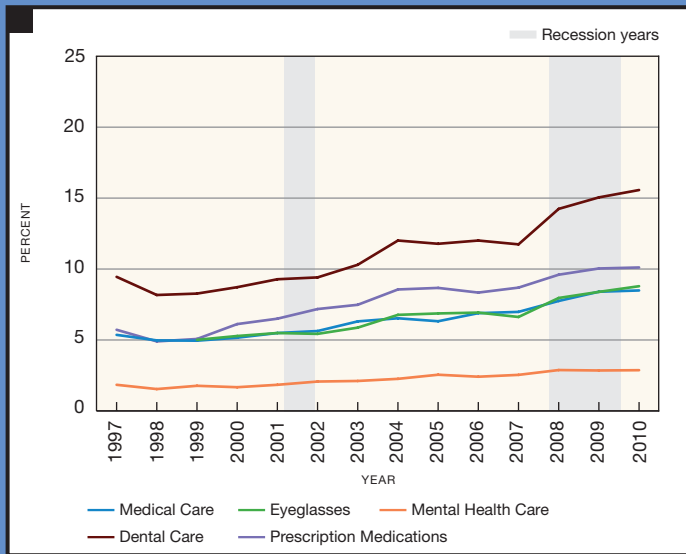
Aggregate Trends in Spending on and Access to Health Care

We turn next to trends in government spending on health care and access to health care. On the matter of spending, one might imagine that, as tax revenues decline, government spending on health care would decline in tandem. This is clearly not the case. To the contrary, resources allocated to providing health care in the United States have continued their secular rise, as figure 4 illustrates.

What about health insurance coverage? Although we're spending more in the aggregate on health, figure 5 shows that health care coverage for Americans has nonetheless been declining, falling from just over 86 percent in 2000 to about 84 percent in 2011. There does appear to be a subtle recession-induced decline in such coverage. However, when one considers insurance among children, we see that it has risen slightly since 2006. Other data also show that health insurance coverage for poor children has continued to improve in recent years. Of course, the trends in asthma discussed above suggest that extensions of health insurance alone cannot prevent all child health problems from occurring, nor has it prevented a greater burden among less-advantaged social groups.

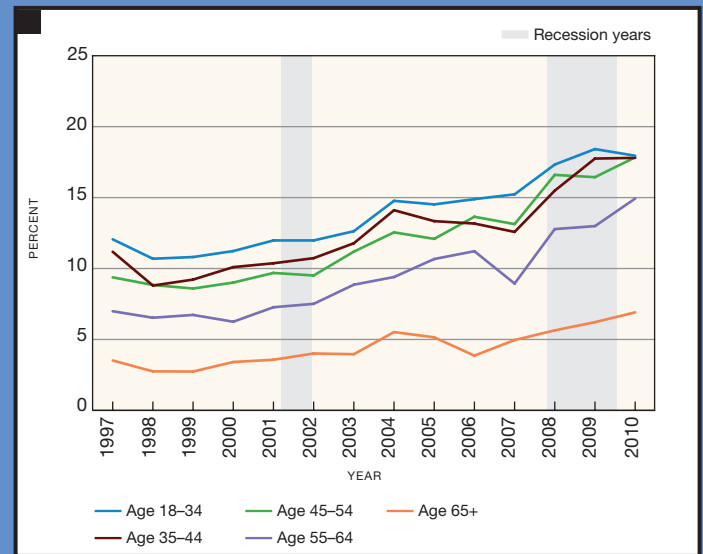
Perhaps most striking among the available indicators is the increase in the proportion of American adults foregoing health care even when they think it is needed. Figure 6 shows that while the percent going without various forms of care has been slowly increasing since the late 1990s, reports of foregone dental care

FIGURE 6. Percentage of adults in the United States who needed but couldn't afford different types of medical care, 1997–2010



Source: Stanford CPI Calculations Based on NHIS IPUMS Data. Minnesota Population Center and State Health Access Data Assistance Center, *Integrated Health Interview Series: Version 4.0*. Minneapolis: University of Minnesota, 2011. <http://www.ihis.us/ihis/>

FIGURE 7. Percentage of adults in the United States who needed but couldn't afford dental care by age group, 1997–2010



Source: Stanford CPI Calculations Based on NHIS IPUMS Data. Minnesota Population Center and State Health Access Data Assistance Center, *Integrated Health Interview Series: Version 4.0*. Minneapolis: University of Minnesota, 2011. <http://www.ihis.us/ihis/>

rose quickly after 2006, from under 12 percent to almost 16 percent by 2010. There were also notable increases over this period in foregone eyeglasses and prescription medications. Similarly, figure 7 reports on foregone dental care, and here again a sharp increase is evident throughout the population, though people over 65 have much lower likelihood of going without this or other forms of health care.

It follows that there's much evidence of recent scrimping on important preventive and curative medical care. Although this scrimping hasn't yet registered in many health outcomes (with the possible exception of asthma), it is reasonable to hypothesize that over the long run it will.

Conclusions

Taken together, these indicators suggest that for most Americans the Great Recession did not have immediate negative health impacts. This is consistent with past research showing that, at the aggregate level, health does not decline in any precipitous way when the economy does.

But there are important exceptions to this conclusion. We've suggested that some mental health outcomes may register more immediate effects and have shown, consistent with this argument, that serious psychological distress is rising, especially among 25–44 year olds. We suspect that mental health outcomes are more likely to register in population statistics because stress may increase not just among those directly experiencing a negative event but also among those who worry that they may

experience one soon. This kind of precariousness has been linked to poorer mental health in a host of past studies.

We've also shown a rising rate of asthma among Black children and a sharp increase in foregone medical care among adults. These results suggest that, in localized and delimited ways, negative health consequences are already being felt. We must be prepared for the possibility of many other negative effects emerging over time. Research has shown that the consequences of economic and other social stressors for health often follow at a lag of many years, due to the complex etiology of disease. We must wait for the data to assess those outcomes.

We should also reemphasize that the foregoing results speak more to the indirect effects of the Great Recession than to the direct effects. That is, the data presented here are of course aggregate and thus may conceal health consequences for individuals who have actually experienced job losses, mortgage failures, or other serious recessionary events. It is at this individual level where past research has shown the largest health effects, and studies that follow these individuals to observe changes in their health will be essential to understand the full effects of the Great Recession on health and health disparities.

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