

Editorial

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The articles in this issue consider the productivity in psychiatric outpatient clinics for children and youth (Halsteinli *et al.*), the interactive impact of mental health and smoking on wages (Jofre-Bonet *et al.*), the spatial pattern of mental health expenditure (Moscone & Knapp) and the impact of depression and pain on labor market, financial, insurance and disability outcomes (Tian *et al.*).

Halsteinli *et al.* (p. 183) analyze the effects of the Norwegian government policy to increase the supply of psychiatric services to children and youths. The 1996 estimate that as many as 60 percent of those in need did not receive psychiatric care led to a government white paper that defined an increase in personnel in combination with an increase in productivity as central political goals for the psychiatric healthcare sector. The study aims to evaluate the effects of this policy, whether change in productivity occurred, and whether such change, if present, is related to personnel mix, budget growth or financial incentives. A panel of 45-65 outpatient clinics in each of the six years from 1996 to 2001 is included in the study and productivity is analyzed according to two input measures (number of university educated personnel and number of other personnel) and two output measures (number of direct and indirect interventions related to the patient each year). The authors report an overall productivity increase of about 4.5% per year throughout the study period. The increase pertained to clinics that were previously both efficient and inefficient, the latter somewhat more so than the former. The authors report that budget and personnel growth had a negative influence on productivity growth, while an increase in the percentage of university-educated personnel improved productivity.

Jofre-Bonet *et al.* (p. 193) examine the documented association between poor mental health and labor market outcomes, smoking and poor mental health, and smoking and labor market outcomes. The authors analyze both the separate and the interactive impact of poor mental health and smoking on wages, a commonly used measure of workplace productivity, and evaluate separately the impact for men and women. The study uses the data from the Community Tracking Survey (CTS), a biennial, stratified random sample of about 60,000 individuals per round conducted in the United States. This nationally representative dataset contains detailed information on mental health status, smoking status and labor market participation and wages. The CTS sample is restricted to 119,883 individuals (ages 18-64), corresponding to rounds 1, 2 and 3 (1996, 1998 and 2000). The results confirm previous findings that poor mental health

is negatively associated with wages (−8% for men; −4% for women), and negatively associated with current smoking (−6.4% for men and −1.7% for women) as compared with never smoking. The impact of poor mental health varies substantially by smoking status for males. Men who are in poor mental health who also smoke have the largest associated reduction in wage rates (−16.3%), relative to those who have never smoked and are not in poor mental health, while the interaction between poor mental health and smoking is insignificant for women. The authors observe that those who smoke and have mental health problems, especially males, have the greatest productivity losses and recommend that interventions address both of these conditions jointly.

Moscone and Knapp (p. 205) explore the variations in local authorities' spending decisions for mental health in England and examine whether a local authority's spending decisions respond to neighboring expenditure decisions. The authors consider a number of reasons why there might be interdependence between local authorities' decisions and label them as demonstrative (stimulus to mimic activities and expenditure patterns of local authorities characterized by good performance), market leader (influence due to exemplarity or good reputation), contextual (the neighboring authorities share common general population characteristics or underlying socio-economic features), directive (common guidance by national government), shared resources (some mental health services are organized at a level higher than the individual local authority and/or serve a population that is not confined to a single administrative area, for example large psychiatric hospitals), and inducement effects (a local authority may act to persuade service users and providers to migrate into or out of an area). The study considered 150 local authorities in England and the 2001-2002 data-set is based on three different sources: (i) data on personal social services expenditure for adults under 65 with mental health problems; (ii) socio-demographic attributes; and (iii) wage rates. The authors report that per-capita mental health spending distributes in clusters, with the highest concentration in metropolitan areas such as Greater London, Greater Manchester and Birmingham, and that spatial autocorrelation characterizes local expenditure decisions, a finding they deem consistent with some degree of policy interdependence between neighboring municipalities. They conclude that actual patterns of spatial interaction may be more complex than simple contiguity, but that positive interdependence is an important feature for decision-making.

Tian *et al.* (p. 219) consider the interaction between

depression and pain and analyze their associations with labor market, financial, insurance and disability outcomes among nearly elderly Americans. The study used the Health and Retirement Survey (HRS), a longitudinal national survey for the biennial tracking of national trends in health and economic well-being among retired and near-retired Americans. Wave 3 of the 1996 round (individuals aged 55-65) was considered, with the exclusion of data on individuals and proxy respondents with absence of depression and pain, leaving a study sample of 7,350 individuals. The measured outcomes included employment and retirement status, household income, total medical expenditure, government health insurance, social security, limitations in activities of daily living (ADLs), and health limitations affecting work. The presence of severe pain, mild/moderate pain or absence

of pain, with or without depression, were evaluated. The authors report that depression and comorbid pain was associated with worse outcomes than depression alone or neither condition, after controlling for socio-demographic status and other chronic health conditions. Although severe pain was present in a small proportion of depressed individuals (10%), the relative adverse effects were large. They accounted for 14% of the depressed that were not employed, 14% of those with government health insurance, 20% of those with limitations in ADLs, and 14% of those with health limitations affecting work. According to the authors, these results suggest the need to enhance the efficiency of care through pain management, depression management or both.