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Commentary

What China's experiment in community building can tell us about tackling health disparities
Community Building and Mental Health in Mid-Life and Older Life: Evidence from China

Peter Muennig

Mailman School of Public Health, Columbia University, MSPH Box 14, 600 West 168th Street, 6th Floor, New York, NY 10032, USA

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ABSTRACT

Disparities in physical and mental health between advantaged and disadvantaged communities are among the largest threats to population health worldwide. These disparities appear to be growing, probably in part because we do not understand how to address their underlying causes. Many believe the underlying causes are thought to arise directly or indirectly from the psychosocial problems underlying poverty, such as hunger, poor housing, drug use, or crime. One logical solution is therefore to provide more community services targeted at addressing these problems within the most disadvantaged communities. However, to date, data on the efficacy of this approach is lacking. China serves as a possible laboratory for studying the efficacy of community-based programs. This is because the extensive community-based programs present prior to economic reforms in 1978 were removed, and then later reinstated in a quasi-experimental manner. In this issue, Yuying Shen uses multi-level models to explore the impact of this experiment on community mental health in a multi-level associational study. She finds that the quantity (but not their length of time in the community) of such services is positively associated with mental health. This study opens the door to more rigorous analyses that might motivate formal social experiments at the community level worldwide. If successful, such experiments might not only transform what we currently know not just about improving health in disadvantaged communities, but also prove transformative for health policy as a discipline.

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Introduction

Whether measured in terms of mental health, physical health, or life expectancy, there are yawning gaps in health between high school completers and dropouts, different ethnic groups, and the rich and the poor in almost every nation on earth (Sorlie, Backlund, & Keller, 1995; Wells, Klap, Koike, & Sherbourne, 2001). Because similar people tend to live together, these groups are usually divided not just into socio-demographic "communities," but also into geographic communities. While such geographic divisions can further exacerbate disparities (e.g., by concentrating wealth or poverty), they do allow policymakers to better target disadvantaged communities with services that they most need.

In this issue, Yuying Shen explores whether general community building efforts have worked in China. Setting aside the question of what works for now, she attempts to explore whether broad community building efforts have any collective impact on health at all. She uses a measure of mental health as an outcome measure, which is probably a much more sensitive measure of community well being than physical health; physical health is difficult to measure and longer exposures to an intervention are needed to effect change.

What do we know, anyway?

The broader question of whether community-building efforts impact mental health is critically important for a number of reasons. First, health disparities between communities are probably greater threats to population health than those that commonly come to mind, such as smoking, obesity, alcoholism, or poorly performing health systems (Muennig, Fiscella, Tancredi, & Franks, 2010). Alarmingly, in many places in the world, these differences in health and longevity between well off and disadvantaged

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E-mail address: Pm124@columbia.edu.

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communities seem to be growing rather than shrinking (Woolf & Aron, 2013), so this problem is becoming more serious with each passing year. Second, it is an important question because such services can be provided to disadvantaged communities by a range of actors including governments and non-governmental community-based organizations. Therefore, once we know what is effective, it should theoretically be feasible to deliver such services within most political economies worldwide. Finally, mental and physical health disparities are probably intertwined at the community level. Therefore, if we can address mental health, we may well impact physical health and vice versa.

Mental and physical health disparities are probably intertwined because living in poor communities comes with psychological stress that may influence both the mental and physical well-being of the residents of these communities (Hill, Ross, & Angel, 2005). In some places, like the famed favelas of Brazil, this means being fearful of going outside of one's home or of having loved ones killed or incarcerated. In others places, like China, it can mean being cold, hungry, or even lonely—when young adults leave these communities to work in bigger cities, they often leave their children and their own parents behind (Szreter, 1999). Higher rates of physical illness add to the mental stress, and higher rates of mental illness might predispose one to physical disease (McEwen & Mirsky, 2002). Therefore, stress-reducing services provided in the community could be important for physical and mental health irrespective of whether such services are medical or non-medical in nature. That is, a clinic or a welfare program could both reduce psychological stress within the community just by providing needed services.

If we could find a way of improving the socio-emotional well-being of communities, we might also be able to improve population mental and physical health. But can we do this with community services? First, forget about which services might work. We need to know whether we can do it at all.

For a few population health threats, the policy solutions are relatively clear. As one example, there is good evidence that smoking rates can be reduced by increasing cigarette taxes (Hill, Amos, Clifford, & Platt, 2013). However, it took 50 years to move from discovering the health threats associated with smoking to devising an effective social policy that would address the underlying problem. The movement progressed from correlational studies to experiments proving that smoking was a threat, to quasi-experimental studies of social policies to determine which policies were effective at getting people to quit and which were not.

Unfortunately, very few community-based interventions have been proven to be effective in the same way that cigarette taxation has (Zaza, Briss, & Harris, 2005). Even when it comes to broader, more generic social policies directed at entire nations, only a handful of experimental social studies exist with health outcomes (Kawachi, Adler, & Dow, 2010).

The Chinese laboratory might provide the answer

Fortunately, while underutilized, we do have a very large and powerful laboratory for studying community health interventions. Starting in 1978, policymakers in China turned to science to solve the nation's social problems. To tackle hunger and poverty, an experiment in economic liberalization occurred, with special economic zones set up as laboratories to test whether the market could solve China's persistent problems with poverty and intermittent hunger (Lin, 1997). This experiment proved successful, and was gradually expanded, but it created problems of its own.

Prior to the economic revolution brought be Deng Xiaoping in 1978, China was divided into small, deliberately planned communities, called communes. These were centrally organized, but were ultimately managed at the local level by committees of community residents. Virtually all communes contained a medical practitioner with rudimentary skills, basic access to education, and basic public health infrastructure (Sidel, 1972). Social welfare was therefore essentially a community affair. The family was the central unit, and the community was the organizing force of the family.

After economic liberalization, the communes were slowly dissolved along with the services that they provided. By the mid-1980s, virtually all of the basic medical providers were gone, and families were left to pay for their own medical care, whether they could afford it or not (Zhu, Ling, Shen, Lane, & Hu, 1989). Often, they also paid fees for education and other programs that were previously provided for free.

In rural areas, young and able parents increasingly migrated to urban centers, leaving grandparents behind to care for their grandchildren (Zhao, 1999). This urban migration not only placed a huge amount of stress on people and their families, it contributed to the further dissolution of communities that were already experiencing the loss of critical social services. Often, those who were newly arrived in cities did not possess the document that was required to receive services, called a *hukou*, within those urban communities that offered them.

There is poor data on mental illness during the pre-1978 era. However, the exceptional gains in life expectancy realized in post-revolutionary 1949 China slowed dramatically after 1978, with annual gains much smaller than in other nations with similar per capita income. Recognizing the problems that were being created by economic liberalization, the Chinese central government worked hard to repair these communities. Thanks to the fiscal benefits brought by economic liberalization, ample resources were available to invest in infrastructure (such as housing or subway systems) as well as community organizations.

What is most exciting about these changes is that they were not uniformly implemented. As with most social policies in China (including economic liberalization itself), the process of community building was done as a series of experiments (Yan & Gao, 2007). In fact, the rebuilding of Chinese communities was perhaps the largest social experiment in history. (At least up to the point that China experimented with health insurance under the New Rural Cooperative Health System.)

Using best practices as an example, general guidelines for community development were devised (Yan & Gao, 2007). The goals of the guidelines included improving economic well being, mental and physical health, educational attainment, neighborhood aesthetics and policing. These goals were to be accomplished via programs ranging from birth control to environmental protection, but localities were given leeway to adopt what they felt was most relevant for their community.

With all of this spatial and temporal variation in the ways that programs were implemented, we should be able to get a much better sense of what works and what does not than we have to date, at least within the Chinese context. That is, we should be able to if we can compile data that encompasses (and defines) enough communities and over a broad enough time span.

What Shen says

In this study, Shen takes a look at these data using multi-level correlations rather than difference-in-difference models. She was therefore not able to dig much into causality, and her dataset prevented her from getting a sense of which community interventions were important for mental health and which were not. Still, while preliminary, this study is particularly important because it could herald a new wave of powerful research that exploits experimental variation within the Chinese laboratory. She finds that the number of services provided is a determinant of mental health. However,

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