Social Networks and Collateral Health Effects

The Harvard community has made this article openly available. Please share how this access benefits you. Your story matters

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Published Version</td>
<td><a href="http://dx.doi.org/10.1136/bmj.329.7459.184">http://dx.doi.org/10.1136/bmj.329.7459.184</a></td>
</tr>
<tr>
<td>Citable link</td>
<td><a href="http://nrs.harvard.edu/urn-3:HUL.InstRepos:4276923">http://nrs.harvard.edu/urn-3:HUL.InstRepos:4276923</a></td>
</tr>
<tr>
<td>Terms of Use</td>
<td>This article was downloaded from Harvard University’s DASH repository, and is made available under the terms and conditions applicable to Other Posted Material, as set forth at <a href="http://nrs.harvard.edu/urn-3:HUL.InstRepos:dash.current.terms-of-use#LAA">http://nrs.harvard.edu/urn-3:HUL.InstRepos:dash.current.terms-of-use#LAA</a></td>
</tr>
</tbody>
</table>
Social networks and collateral health effects
Nicholas A Christakis

BMJ 2004;329:184-185
doi:10.1136/bmj.329.7459.184

Updated information and services can be found at:
http://bmj.com/cgi/content/full/329/7459/184

These include:

References
This article cites 9 articles, 5 of which can be accessed free at:
http://bmj.com/cgi/content/full/329/7459/184#BIBL

5 online articles that cite this article can be accessed at:
http://bmj.com/cgi/content/full/329/7459/184#otherarticles

Rapid responses
One rapid response has been posted to this article, which you can access for free at:
http://bmj.com/cgi/content/full/329/7459/184#responses

You can respond to this article at:
http://bmj.com/cgi/eletter-submit/329/7459/184

Email alerting service
Receive free email alerts when new articles cite this article - sign up in the box at the top left of the article

Topic collections
Articles on similar topics can be found in the following collections

Sociology (342 articles)
Other communication (298 articles)
Patient - other (548 articles)

Notes

To order reprints follow the “Request Permissions” link in the navigation box

To subscribe to BMJ go to:
http://resources.bmj.com/bmj/subscribers
Social networks and collateral health effects

Have been ignored in medical care and clinical trials, but need to be studied

Since a patient or a clinical trial participant is connected to other people through social network ties, medical interventions delivered to a patient, quite apart from their health effects in that person, may have unintended health effects in others to whom he is connected. The cumulative impact of an intervention is therefore the sum of the direct health outcomes in the patient plus the collateral health outcomes in others (figure). These effects, in both the patient and in their social contacts, might be positive or negative. Doctors, trialists, patients, or policy makers might see reason to take them into account when choosing treatment or evaluating benefit.

For example, treating depression in parents may increase their propensity to vaccinate their children, thereby saving children's lives. Replacing a hip or preventing a stroke may mean that a person is better able to care for his spouse, thus improving her health. Delivering a weight loss intervention to one person may trigger substantial weight loss in that person's friends. Giving a patient superior end of life care may decrease the stressfulness of the patient's death and thus decrease his spouse's propensity to die during bereavement.1

These collateral health consequences that accrue to others are known to social scientists as externalities. They are similar to the increase in value a person's neighbour may see if the person refurbishes his property; the person himself derives no benefit from the neighbour's windfall, even though he has invested resources and created this new value. Here, however, we are considering not monetary externalities but rather specifically health externalities. Moreover, in the healthcare arena patients may derive value from such effects. For example, since 89% of patients feel that a good death involves not burdening family,2 patients might prefer hospice care over standard terminal care if they felt it offered health benefits to their loved ones.3

When the cost-benefit assessment is made by policy makers with a collective viewpoint, all the downstream costs and benefits of health care accruing to a group might be relevant, and the argument in favour of accounting for collateral effects might be even more compelling than that perceived by individual doctors or patients. From a societal perspective the assessment of the cost effectiveness of medical interventions might change substantially if the benefits of an intervention are seen as including the collateral positive effects and the costs as including the collateral negative effects.

Such a concern for collateral effects could, however, also lead to unexpected results. For example, preventing a death from heart attack, which is clearly desirable from the individual's perspective, may mean that we have to forego the motivation that would otherwise have accrued to others to whom the patient is connected to improve their own health habits. Another provocative implication is that policy makers might value socially connected individuals—such as married people—more when it comes to health care since benefits might be multiplicative in such people.4

We have scattered evidence supporting the plausibility and likely magnitude of such collateral health effects. The most well known example is that the death of one spouse increases the risk of death in the other.5–7 Moreover, morbidity in one spouse can contribute to morbidity in the other—for example, via caregiver burden.6 Breast cancer in one woman may motivate others to whom she is connected to have mammography.7 Exercise or smoking cessation in one person may prompt numerous others to behave similarly. Conversely, there may be epidemics of disorders such as obesity, alcoholism, suicide, or depression that might spread in a peer to peer fashion.8 Even loose social connections can be conduits for such effects; cancer in a celebrity, for example, may motivate many people not known to the index case to undergo cancer mammography.
Condoms and prevention of HIV
Are essential and effective, but additional methods are also needed

Promotion of condoms has been a mainstay of HIV prevention policy. Over the past few years, however, the value and effectiveness of condoms have increasingly been called into question. The growing “abstinence only” movement in the United States questions the provision of condoms as part of the policy and messaging of the US Agency for International Development (USAID) and claims that condoms have had little to do with the successes achieved in reducing HIV in countries such as Uganda.1,2 Senior officials in the Roman Catholic Church also continue to argue about the morality of condom use and dispute its efficacy.3

But what does the evidence tell us? A recent review from the National Institutes for Health says that condoms are protective against HIV infection,5 reducing the probability of HIV transmission per sex act by as much as 95% and reducing the annual HIV incidence in serodiscordant couples by 90-95% when used consistently.6 However, the impact of inconsistent use of condoms is less substantial: a meta-analysis found that condom use of variable consistency among serodiscordant couples reduced the annual HIV incidence by 69%.7 This illustrates how the protection provided by a condom is dependent both on its efficacy against HIV transmission per sex act and the consistency with which it is used. This is intuitive, yet the consistency of condom use is less commonly factored into scientific and policy debate. Evidence from around the world highlights the extent to which patterns of condom use are influenced by the form of partnership in which they are being used. Interventions can achieve substantial increases in the use of condoms in commercial and casual sex partnerships. Several studies report high levels of condom use after interventions in commercial sex.8-10 But even in settings where HIV infection is widespread, the use of condoms in primary partnerships remains low—representative surveys of women in 13 African countries found that fewer than 7% report condom use in the last sex act with their regular partner.11 Surveys of sex workers in Asia generally find that, although many use condoms with their clients, fewer than 40% report using condoms in their last non-commercial sex act. Unless one partner knows they are HIV positive or