Economic Burden of Depression in Pakistan

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Introduction

Economic burden, because of ailments in any area would need urgent attention. Talking about mental health, the scenario 'is such that nearly 450 million people suffer from mental and behavioral disorders. These include: depression; bipolar disorder; schizophrenia; epilepsy; alcohol and drug use disorders; Alzheimer's and other dementia; post-traumatic stress disorder; obsessive compulsive disorder; panic disorder; and primary insomnia. Already, mental health problems represent five of the ten leading causes of disability worldwide, amounting to 12% of the total global burden of disease! Mental and behavioural disorders have a large impact on individuals, families and communities. Individuals suffer the distressing symptoms of disorders. They also suffer because they are unable to participate in work and leisure activities, often as a result of discrimination. They worry about not being able to shoulder their responsibilities towards family and friends, and are fearful of being a burden for others. It is estimated that one in four families has at least one member currently suffering from a mental or behaviour disorder. These families are required not only to provide physical and emotional: support, but also to bear the negative impact of stigma and discrimination present in all parts of the world. The burden on families ranges from economic difficulties to emotional reactions to the illness, the stress of coping with disturbed behaviour, the disruption of household routine and the restriction of social activities. Expenses for the treatment of mental illness often are borne by the family either because insurance is unavailable or because mental disorders are not covered by insurance. Mental disorder poses significant economical burden on the individual and their families. There is the cost of providing care, the loss of productivity and some legal problems (including violence) associated with some mental disorders, though violence is caused much more often by "normal" people than by individuals with mental disorders. 2 Investigation 3 has shown that depression increases medical utilization for a variety of somatic complaints, the most common being weakness, lethargy, headaches, backaches, insomnia and gastrointestinal disorders. These complaints often produce unnecessary hospitalizations, physician visits, diagnostic tests, and prescriptions for analgesics, anxiolytics, sedatives and gastrointestinal medications. They use emergency services three to four times as often and call about health problems and for medication changes four to five times more often than non- depressed enrollees. The untreated or inadequately treated depressed patients increase non-psychiatric health care costs. In developing countries, more descriptive studies are needed on the "informal" sector of care (family and traditional healer) and the formal sector of care including primary care, general hospitalization and specialty psychiatric providers. 4 This description should include the payment method of the different providers, the financial incentives inherent in the payment mechanisms and the economic value of the family’s contribution to the care of mentally ill. In Pakistan the magnitude of illness is serious, the current studies show the pattern as: prevalence of 6% depression, 1.5% for schizophrenia, 1-2% of epilepsy and 1% of Alzheimer's disease. 5 Besides other social evils, these mental morbidities are responsible for the high suicide

rate as noted recently. The prevalence of depressive disorders is the highest, followed by schizophrenia and substance abuse in that order. 5 There are two sectors in Pakistan, Private and Public, the private sector works on fee for service on consultation and medical cost sponsorship. This sector is quite costly. The public sector though aims at providing free consultation services but the treatment and associated burden is borne by the patients who forms the largest segment of economically deprived population. There is a provision of voluntary health insurance at a limited level, the state does not bear the responsibility for sponsored health care, the health budget is less than 1% of GNP of which 0.4% is allocated for mental health6 but this allocation is not in implementation as such. During 1999-00, the overall expenditure on health services was only Rs. 14.6 billion or 0.5% of the GNP: lower than even the 1996-97 budget when it was 0.8%. 7 Depression which is a serious mental illness is causing enormous economic burden when the direct and indirect costs are taken into account with the parameters like: Inpatient hospital (day), Skilled nursing facility (day), Outpatient treatment (visit), Case management (time), Medication (dose/day), Emergency care (visit), Medical Care Treatment, Inpatient hospital (day), Outpatient (visit), Lab tests (procedures), Social Services, Rehabilitation services (days, hours), Supported housing (day), Family/ Informal Care Service, Transportation (trips), Maintenance assistance (dollars). More than 35% of the people are living below the poverty line and hence it is understandable that the serious predicament the people are going through. The population of Pakistan is more than 140 million of which 6% are suffering from depression. 5 Fifty percent of the sufferers never take any treatment; therefore if we assume that only 3% of the sufferers (42,00,000) are taking treatment, the cost burden may be really serious. Out of the total 140 million population of Pakistan 6% suffers from depression, which comes to 84,00,000 of the population. 50% of the sufferers do not seek treatment at any stage, this brings the figure of 42,00,000 who seek treatment. According to the calculation total cost of depression comes to around Rs. ,50,600 per annum which when multiplied with 42,00,000, health care seekers the amount comes to 632.5 billion Pakistani Rupees which is equal to 10.54 billion US dollar (1 US dollar = 58 Pak. Rupees). There are limited facilities for insurance, some companies provide medical cover to employees, and the state does not take adequate burden of health care cost. The figure of Rs. 5,000 earning / month is from a selected section of society, combining the total family income. Many cannot afford the cost, whereas the Government hospitals cater to large segment of poor patients but fail to provide appropriate medicines free of cost which the patient has to provide for himself.

Suggestions

The startling gap between effective and available interventions can be reduced by improving government policy, planning, and service development. Adequate and sustained financing is one of the most critical factors in the realization of viable mental health system. 1. Allocation of resources specifically to priority underserved and at-risk populations (e.g., people with severe mental disorders, children and adolescents, women, the elderly, specific regions, specific income strata). 2. Prepayment systems (e.g., general taxation and social insurance) that include mental health services are one clear way to achieve these objectives. 3. Accountability for existing mental health resources should be

a critical component of planning and budgeting. 4. Information systems for monitoring expenditures and services are critical to ensure equity, effectiveness and efficiency. 5. Shifting funds from institutions to community care. Integration of mental health with primary care. During health services transitions, special funding -sometimes called "double funding" or "parallel funding" -is needed to ensure that new services are firmly established before existing services are closed. This approach is often useful during the transition from hospital-based services to community-based services. 6. Government should share one-third of the cost burden, one-third through voluntary organizations, support from international organizations and social insurance and the remaining one-third by the individual pockets to start with. If these suggestions are implemented, one may hope for an improvement in the existing scenario.

Reference

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