FREE PHARMACOLOGICAL TREATMENT FOR SCHIZOPHRENIA IN DEVELOPING COUNTRIES – CASE FOR A PUBLIC HEALTH INTERVENTION

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Schizophrenia ranks 6th in the league of causes of disability worldwide as measured by Years of Life lived with Disability[1]. Consequently in many developed countries it has been target of major service initiatives such as early intervention for psychosis[2]. The treatment of severe mental illness, particularly schizophrenia has not received much attention in developing countries mostly due to focus on high prevalence disorders such as depression. This is unfortunate. These countries have predominantly younger population, an age of high risk for schizophrenia. It has been estimated that about 45% of those suffering from schizophrenia worldwide by the year 2000 were living in the developing world[3].

Two important articles in this issue, both from India, highlight the issues we face in the care for this disorder in our countries. While Grover et al in an exhaustive review on the cost of treatment for schizophrenia show that schizophrenia results in high cost for the health systems, Prathap in his insightful guest editorial highlights an often-neglected issue of putting the evidence in proper context. These articles should help us to think innovative strategies to provide care for those suffering from this chronic disorder.

The care for schizophrenia in developing countries is characterized by the following:

- Treatment limited mostly to the acute episodes.
- Lack of continuity of care.
- Lack of legislation or its implementation where it exists for the care of those who refuse treatment.
- The sole responsibility of the family to provide the care due to almost total absence of formal social, psychological or rehabilitation services.

Most individuals are, therefore left to cope with this devastating illness on their own[4]. A great majority of patients are simply not able to afford even the basic treatment which results in high untreated prevalence of schizophrenia in the form of undetected as well as inadequately and partially treated cases[5]. While the prognosis of schizophrenia in developing countries has generally been found to be better than that in developed countries, the great burden of untreated cases does put a huge burden on the families of the sufferers. Besides, this untreated prevalence results in enormous public health consequences which are now well documented in context of literature on duration of untreated psychosis These include increased co-morbid substance abuse, suicide, increased treatment resistance and perhaps a steep decline in treatment response, impairment in cognitive and neuropsychological functions, offending behavior, vocational failure and overall poor outcome[6].

This pattern of care and its consequences are not much different from the care of other chronic diseases in developing countries. The present situation of care for chronic disorders such as Diabetes Mellitus in developing counties has been succinctly described by the WHO as RADAR syndrome[7]. The RADAR syndrome is characterized by following: the patient appears in acute episode, is treated, discharged from the care and then disappears from radar screen of caregivers, only to reappear in the case of another relapse. However, there are two important differences which make the care of schizophrenia even worse when compared to other chronic medical conditions. These are:

1. Almost a complete lack of involvement of primary care physicians in the care of those suffering with a psychotic disorders. (In contrast to even other psychiatric disorders such as depression in which the general practitioners are now getting increasingly involved, though not optimally).
2. Inability of the caregivers and those who suffer from the disorder to influence policy makers and the health professionals for the allocation of appropriate resources.

While there are major policy initiatives for the care of other chronic disorders even in resource poor countries there is hardly any concern for schizophrenia. This is unfortunate in view of not only the huge burden of disease caused by the disorder but also the fact that the cost effective interventions for schizophrenia are available and can be easily implemented in the community. Out of 20 recommendations for optimal treatment suggested by Schizophrenia Patient Outcome Research

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Team (PORT), 14 relate to the pharmacological interventions and ECT. The researchers in this project were also asked to rate all the interventions available for schizophrenia in their ease of implementation. Pharmacological interventions were rated highest on the ease for implementation compared to the other non-pharmacological interventions[8].

Fortunately, the pharmacological treatment for schizophrenia is not expensive. Grover et al in their review in this issue point out that the monthly cost of treatment in India with chlorpromazine is Rupees 55, an equivalent dose of trifluperazine amounted to Rs. 25/ month, risperidone Rs 60 and clozapine Rs. 225 per month. Based on our own experience with a pilot project in which we are providing free pharmacological treatment in defined catchment area (district Peshawar), the average cost for 6 months treatment with the cheapest available local brands of atypical antipsychotics is Rs.8640.

The major problem, however, is to ensure the access to the treatment and adherence to it. One of the major reasons for the poor compliance in most resource poor countries including our own is the inability of the patient to afford the treatment although as discussed earlier it is relatively inexpensive.

What can be done to cope with this situation? As mentioned earlier the situation is generally not different from other chronic diseases like Diabetes Mellitus. It would be appropriate to look at the solutions which have been suggested in other chronic conditions. A cursory look at the interventions for these disorders would suggest a sharp contrast with schizophrenia. In almost all of the chronic disorders the emphasis is now on a public health approach to combat the burden of disease caused by non communicable diseases particularly in developing countries. Various public health approaches have been tried and implemented. These range from early detection and aggressive public health campaigns to address the high risk factors, to providing free access to the treatment. In case of schizophrenia we have consistently lagged behind in advocating a public health approach. With the exception of efforts to reduce the stigma for mental disorders in general, the public health interventions have rarely been described in schizophrenia.

There may be genuine reasons for lack of this approach. Schizophrenia is a low prevalence disorder. It is not easy to diagnose or screen with tools which can be applied at the populations' level. The primary prevention is practically not feasible. The effective interventions which could be applied at the community level were not available till recently. However, I believe the case for secondary prevention has generally been not advocated well at least in developing countries where the treatment gap is very wide mainly due to poor access to the treatment.

It is now time that the mental health professionals in developing countries advocate a public health approach for coping with the disorder. The cornerstone for this strategy should be provision of free pharmacological treatment for those who can not afford it. In Pakistan many health initiatives are based on improving the access to the treatment for poor patients. For example, the provincial government of North West Frontier Province has established an endowment fund which will help to provide free treatment for Hepatitis for those who can not afford it. Six months treatment of oral drugs for a single case of Hepatitis C on average would costs Rs.45000. There are similar other initiatives for Diabetes Mellitus, Tuberculosis and many other chronic disorders requiring long term treatment. The drugs costs for the treatment of all these disorders are much higher than that needed for schizophrenia.

Providing pharmacological treatment either free or at subsidize rates to the poor families will only help to meet less than 5% of the total cost these family have to bear. The rest would still be born by the families, not to mention the emotional and social costs they are doomed to pay for the care of their dear ones. It can not be overemphasized that the family is already subsidizing the treatment of schizophrenia for society and the state at large by providing the social, psychological, residential and occupational support which constitutes the major proportion of the total cost of treatment by the state sponsored institutions in the West. Providing free access to the treatment for those who suffer from schizophrenia needs to be advocated forcefully, not as a charity measure but as a cost effective public health intervention.

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