**Review Article**

**Poverty and common mental disorders in India: the inseparable twins**

**Shyamkumar Sriram**

Department of Health Services Policy and Management, University of South Carolina, Columbia, South Carolina, USA

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*Correspondence:*  
Dr. Shyamkumar Sriram,  
E-mail: shyam.silverhawk@gmail.com

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**ABSTRACT**

CMDs are a significant cause of morbidity and disability. A large proportion of the population of India lives below the poverty line. This policy report aims to contribute to India’s CMD prevention strategy by reviewing the relationship between CMDs and poverty. While more Indian studies are needed, this review identifies access barriers and social security insufficiencies and recommends measures to address them.

**Keywords:** Common mental disorders, Poverty, Government of India, National mental health program

**INTRODUCTION**

Home to over 17% of the world’s population, India is a poor country with 1.24 billion people. Nearly 42% of the population of India lives below the poverty line, and 35% lives on less than $1 per day. In addition to high rates of poverty, there are wide disparities in the distribution of wealth and health between the rich and the poor. Important indicators, such as the infant mortality rate (IMR) and having an institutional delivery, highlight these wide disparities. Among the poorest wealth quintile in India, the IMR is near 82 per 1,000 live births, yet only 34 infants in 1,000 live births die in the richest quintile, where pregnant women are six times more likely to deliver in an institution. The private sector, the largest segment of the country, accounts for 58% of India’s hospitals and 81% of its doctors. The World Bank report clearly shows that India’s OOP health expenditure, which is 89.2%, is a significant barrier to healthcare utilization. Due to the lack of financial protection, approximately 20-28% of diseases in India remain untreated. Nearly 39 million people in India become impoverished every year due to high OOP health expenditures, and only 11% of India’s population is protected by any form of health insurance. India is undergoing a period of epidemiological transition with 53% of deaths and 44% of DALYs lost attributable to non-communicable diseases including mental health conditions.

**RATIONALE**

Mental health problems are a silent epidemic affecting 13.7% of the people in India and contributing 31% of years lived with a disability. In India, mental, neurological, and substance abuse disorders increased by about 44% between 1990 and 2013, and they are projected to increase by another 23% by 2025. CMDs include depression and anxiety disorders that are classified in ICD-10 as “neurotic, stress-related, somatoform and mood disorders.” Some studies showed that the prevalence of CMDs was around 46.5% and the observed incidence of CMD was around 1.8% during a 12-month period. Evidence from multiple studies in India identifies poverty as an important risk factor for CMDs. Systematic reviews showed that around 79% of studies showed positive associations between poverty and CMDs. Depression and emotional distress that manifest as somatic symptoms are strongly associated
with poverty. However, the relation between CMDs and poverty is symbiotic and highly complex. In addition to a number of associated health problems, CMDs have also been linked to lower economic productivity and high healthcare expenditures. Despite the high disease burden of CMDs and the established bidirectional relationship between poverty and CMDs, India’s programs and interventions to address them are only rudimentary.

AIMS
- To identify the programs and interventions currently in place to address CMDs and poverty in India.
- To provide appropriate recommendations to the Government of India (GOI) regarding the programs/policies and interventions to be undertaken for early detection and treatment of CMDs and to address the underlying determinant of poverty.

FINDINGS
The National Mental Health Program mainly focused on severe mental disorders, but CMDs were not prioritized. Even after mental health was prioritized under the GOI’s Twelfth Five-Year Plan, no specific plans for addressing CMDs and poverty were established. Access to healthcare facilities and financial protection mechanisms are necessary to dismantle poverty and treat CMDs. Access is affected by the lack of mental health workers and financial barriers. India has only 3500 psychiatrists (75% of which are located in urban areas), and needs 9000 psychiatric nurses and 1600 social workers. The Medical Council of India is taking steps to increase the mental health manpower, but those steps are in nascent phases. Most CMDs could be treated as outpatients, but the National Health Insurance Program for the indigent, Rashtriya Swasthya Bima Yojana (RSBY), provides financial coverage only for hospitalizations and does not cover any outpatient services. Given the high OOP healthcare costs related to CMDs, this causes significant access barriers. Many psychological and pharmacological interventions to reduce CMDs have been proven to be effective and cost-effective, but they still have not been adopted by national policy-makers. Poverty alleviation through the provision of micro-credit using self-help groups are done in some parts of India. These micro-credit activities improve the mental health condition of women since they feel better because they are able to contribute to the financial status of the household. However, there are no such nationwide programs of the GOI, and no such measures are provided for men. No interventions target the negative synergy caused by poverty, lack of education, and CMDs.

RECOMMENDATIONS
Lay health counsellors
PHC physicians in the public and private sectors serve the majority of the population. Recognition of CMDs by PHC physicians is very low. Evidence shows that training PHC physicians and lay health workers for early diagnosis of CMDs has better health outcomes for patients. The creation of a cadre of lay health workers in all PHC facilities along with the mandatory training of all doctors and lay health workers for early detection, treatment initiation, and quick referral for CMDs should be implemented. Early detection and treatment initiation reduces the costs of treating complicated illnesses and prevents work days lost for the poor. However, given the limited resources available in India, hiring a new cadre of workers may be difficult.

Mental health care integration
With 23,391 PHC centres and 145,894 sub-centres, India has an extensive public health infrastructure. Integrating the treatment of CMDs into the routine PHC has good outcomes. The World Health Organization (WHO) recommends that effective mental healthcare can be provided at the PHC level if the country has a well-functioning PHC system. WHO recommends that specialists supervise PHC physicians wherever possible. Since India has a good PHC infrastructure, the GOI should establish mental healthcare integration into PHCs. This should be complemented by an increase in the residency options for psychiatry to increase the number of specialists to treat advanced cases and to supervise the PHC physicians, which will be expensive for the GOI to implement.

Poverty alleviation measures
Poverty has a direct effect on the development of CMDs. The Twelfth Five-Year Plan highlighted the need for the provision of social support to the mentally ill. The GOI has a number of poverty reduction programs focussed on specific populations. However, no specific social programs are available for mentally ill people. The GOI should establish a national agency that offers economic and social assistance for the mentally ill and provides financial support for poor people to prevent the development of CMDs. Also, RSBY does not cover psychiatric outpatient visits. The recommendation to cover outpatient visits under RSBY will be made to the GOI. It will be expensive to implement the RSBY expansion and poverty alleviation measures, but ultimately these measures will save money in the long run.

LIMITATIONS
To advise the GOI, this report used published studies on CMDs and poverty, most of which focused on mental illness generally and not specifically on CMDs. Indian studies are very limited, and studies from different parts of the world may have problems when they are applied to the Indian settings. Only literature in English was used for the report. More credible India-based studies are needed. The recommendations were based on studies done in smaller parts of India and abroad.
applicability of the findings of the studies done with limited samples to the country as a whole is debatable.

CONCLUSION

India has a large population, around half of which is poor. With the high prevalence and incidence of CMDs and the established bi-directional relationship between mental health and poverty, the need to tackle both factors at the same time is vital. CMDs have the potential to affect workers’ health and productivity, and unaddressed poverty leads to CMDs. It is important to implement the recommended measures since they aim at tackling both problems concurrently. With high levels of poverty, high OOP costs of private healthcare expenditures, low public health expenditures, poor facilities, and shortage of manpower for mental healthcare, the GOI should allocate more resources to improving access to mental health and take appropriate poverty alleviation measures. Improved mental healthcare will save costs and result in better economic gains and a healthier population. In India, mental health is not prioritized in the community and the family, thus it is the role of the government to make it a priority. Helping people with mental illness is vital for protecting human rights. The GOI is the guardian of the health of its citizens, thus it is the duty of the government to acknowledge and take appropriate steps to protect the mental health of its population. Thus political commitment is necessary to implement the recommendations proposed by this policy report.

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