Investigating the economic cost of suicide and self harm

This paper attempts to describe;

1. Why this is an important and current topic?
2. Do Suicide and Self Harm belong together?
3. What components/costs can be measured?
4. What additional factors need to be taken into account when examining suicide from this perspective?

1. Why this is an important and current topic?

Over the course of the last 40 years a number of organisations and individuals have undertaken research into the economic cost of suicide and self harm. Predominantly, most of the research has been concerned with suicide. A wide range of literature has been surveyed and while some articles have a more specific focus than others, most either accept and/or actively support the presupposition that suicide and self harm are a huge cost to the economy, both locally and internationally. A number of papers use this fact as a justification for arguing that more money should be allocated/spent nationally on suicide prevention programmes and the understanding of self harm.

In surveying the literature, the intention has been to try to establish whether there is any agreement about

(a) What costs can be measured and
(b) What additional factors need to be taken into account when examining suicide from this perspective?

2. Do Suicide and Self Harm belong together?

While most of the literature located focuses on Suicide, there is a clear link between Suicide and Self Harm. Many who self harm go onto commit suicide. One argument might be that more money spent on understanding and recognising the dangers of self harm would become an important part of a suicide prevention programme.

3. What components/costs can be measured?

A number of methods are used.

These methods are "applied" to the question of Suicide and Economics. They have not been specifically designed for it. As will be evident from the bibliography below, I've consulted quite a wide range of literature, and while these approaches are consistent across the literature, the descriptions / interpretations of the approaches may vary somewhat. What I've attempted to do is find descriptions, which as far as I can see, are broadly inclusive of all the literature.

There are limitations in the use of each approach. I've not included a description of the limitations here so as to keep the descriptions of each of the methods fairly brief.

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Cost of Illness Studies:	Cost of illness studies estimate all the resource consequences associated with a specific disease or condition. They help raise the economic profile of particular problems. They are not of themselves an argument for additional resources. They can be very important in highlighting the proportion of the cost burden of particular health problems in any society
Economic Evaluation Methods:	**(i) Cost Effectiveness Analysis:** involves the systematic comparison of the costs and outcomes of alternative interventions in which the outcomes are measured in terms of health units. Outcomes are assessed in terms of the number of lives saved or the number of life years gained. **(ii) Cost Utility Analysis:** a subset of the above in which health outcomes are measured in terms of quality adjusted life years (QALY's). Therefore, it takes into account the changes in the quality of life as well as prolongation of life achieved by a programme or intervention. **(iii) Cost Benefit Analysis:** is where the relevant outcomes are measured in monetary units.
Assigning Money Values to Health Outcomes:	There are three/four main methods **(i) Human Capital Approach:** This approach estimates loss by approximating current market values for lost productivity in the future. **(ii) Willingness to Pay Approach:** Unlike the human capital approach, which estimates the market value of human productivity, willingness-to-pay reflects the societal value of life by estimating the amount of money people would be willing to pay to avoid a suicide death. The willingness-to- pay approach is believed to assign a greater economic value to lost life than the human capital approach, as it encompasses the psychological and physical burden of pain, suffering and lost quality of life. **(iii) Contingent Valuation:** The contingent valuation method (CVM) is a survey-based, hypothetical and direct method to determine monetary valuations of effects of health technologies. The survey embodies the Willingness to Pay approach above, but additionally attempts to test respondent / presumed responses against socio-economic and demographic characteristics (i.e. age, education, gender, household income etc) **(iv) Revealed Preference:** refers to the observation of actual consumer choices involving health versus money.

Within most of these studies, the values/components are described/broken down as follows

(The table below has been put together from a survey of all the literature below. Slightly different names may be used in some of the articles, but the table below summarises all the costs that these describe.)

HUMAN	DIRECT COSTS	INDIRECT COSTS
• Values individuals. Attempts to place a value on their lives over and above the value of their productive work • Also includes aspirations of life such as being aware and being capable of reflection and feeling • Grieving by survivors	• Ambulance Services • Hospital Services • Physician Services • Autopsy Services • Funeral/Cremation Services • Police Investigations • Counselling • Continuing Care/Rehabilitation • Drug Treatment of Various Disorders	• Potential Years of Life Lost • Discounted Future Earnings • Informal Care • Private Expenditures • Social Welfare • Lost Productivity • Mortality • Homelessness • Prisoners • Unemployment

Not all would accept that the arguments/descriptions above are valid. Some would argue (although I appreciate it sounds cynical) that there is/can be a net saving as a result of a suicide.

4. What additional factors need to be taken into account when examining suicide from this perspective?

THERE IS NO TRADITION OF APPLYING ECONOMIC EVALUATION TO ANY ASPECT OF MENTAL HEALTH CARE IN IRELAND:

O'Shea and Kennelly highlight this starkly when they say

> "*There has been little or no attention paid to economic aspects of mental health in Ireland up to now, so this report is novel in its coverage and focus. There has been no tradition of economic analysis of mental health data and no dedicated health economists working in the field. There is no consistent database that brings together economic and social information on mental health. There is good information on inpatient activity, but little on anything else. Data on national prevalence rates is limited. Unit cost data is not systematically collected, making it difficult to examine the relative costs of various programmes. Similarly, we know practically nothing on the consequences for Irish society and the economy on the impact that mental health problems can have on many aspects of life including physical health, family relationships, social networks, employment status, earnings and broader economic status. We know that mental health problems can lead to stigma and discrimination, but know little about the direct impact both can have on the lives of people with mental health problems and their families".*

What this means is that, essentially, what data/figures we possess are educated guesses based on work/data derived from other countries. There is very little reliable information on the effect that mental health problems have on employment, wages earned or hours worked in Ireland. It is likely that people with mental health problems earn less than the average industrial wage.

COST ESTIMATES FOR OUPUT LOSSES:

As far as sucide is concerned, O'Shea and Kennelly use data to suggest that up to 90% of people who die by suicide have a mental health problem. If that assumption is correct, they infer that lost output due to suicide attributed to mental illness in Ireland amounted to approximately €214,652,000 in 2002. Provisional data, plus allowance for inflation gives an estimate for 2006 of €206, 992, 000. These are huge sums of money, which if looked at in terms of national income and expenditure, might well be offset by the cost of increased suicide prevention programmes and staffing (I don't have figures for these to compare/contrast).

PRIORITIES IN HEALTH

O'Shea and Kennelly in their 2008 report "The Economics of Mental Health Care in Ireland" while not focussing specifically on Suicide (but not excluding it either) set out to conduct a Willingness to Pay/Contingent Valuation study, to discern how people ranked mental health care programme alongside other health care priorities such as a Cancer Programme and an Ageing Programme. The criterion for judging the priority given to each of the above was based on people's willingness to pay extra taxation for improvements or developments in the above services. There was no question of people being expected to pay in real life, but it was seen as a fair measure of the priority people accord to each of these services.

Some interesting points arise in the analysis of the data from the survey.

People were asked which three areas of health care provision and prevention that they would prioritise if more resources were available. Respondents were shown a list of fourteen areas. Cancer was first. Suicide was second. Mental Health was sixth. It's striking that people would like to see more resources devoted to suicide. What's even more interesting is that "Suicide" appears to be seen as distinct from "Mental Health". This could be attributed to a number of factors.

WHY DOES THIS MATTER?

At least, to some extent, governments govern by consent. Their policies are based on a mix of ideology and public perception. Perhaps an additional facet which needs to be added to this is "Understanding".

Unlike Suicide, there can appear to be no clear understanding in the mind of the many members of the general public, about what mental health is, or the range of conditions/issues associated with it. They may be aware of particular conditions, but tend to see these as areas which should be treated medically – as part of the general health care system.

There can sometimes be stigma attached as well, which will not always allow for a full and frank discussion of mental health issues.

Additionally, people appear to feel that there is little likelihood of them suffering from mental illness. Statistics tend to show otherwise. However, the fact that so many people feel this way is an indication that there is no clear understanding nationally of the importance of mental health in their lives. It is seen as a negative issue which affects a small proportion of the population, rather than something that if cherished can enhance their lives.

This matters, because lack of clear understanding, as well as priority, gives no impetus to those who govern, to either improve services and the finances attached to them or sufficient will to understand the necessity to develop such services.

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