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ADDICTION ECONOMICS: TRACING THE MARKET GROWTH FOR DRUG RECOVERY AND REHABILITATION SERVICES IN INDIA

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ABSTRACT

Alcohol, tobacco and drug addiction seems only to be an ever growing problem in India, among all parts of society alike, for various cultural and socio economic reasons. Given the issue, the government and non-governmental organizations have attempted to implement several programs ranging from prohibition of addictive products, criminalization, rehabilitation programs, taxation, and community based initiatives. In order to trace the market growth for such measures and rehabilitation services, it is crucial for policy makers to understand the economics of the market and the contributions that economics as a discipline can make to long term design of de-addiction programs. This paper will shed light on the current schemes implemented in India to tackle the issue, and shed light on the economics of the market for drugs. The paper will then evaluate the effectiveness of various measures such as taxation, and finally pose policy recommendations for moving such measures from a focus on prohibition to a focus on rehabilitation and tackling social stigmatization.

Keywords: Addiction economics, Drug addiction, Drug Control, Socioeconomic, Market growth

INTRODUCTION

It is well known that alcohol and drug addiction is a pervasive problem in India, among all classes of citizens and particularly those from a lower socio economic strata of society. In 2019, the National Drug Dependence Treatment Centre (NDDTC) of the All India Institute of Medical Sciences (AIIMS), New Delhi submitted its Report "Magnitude of Substance Use in India" (PIB, 2019). At the national level, about 14.6% of people are current users of alcohol, i.e. about 16 Crore people. About 2.8% of Indians (3.1 Crore individuals) reported having used any cannabis product within the previous 12 months (PIB, 2019). About 1.08% of 10-75 year old Indians (approximately 1.18 crore people) are current users of sedatives (non-medical, non-prescription

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use) (PIB, 2019). Nationally, it is estimated that there are about 8.5 Lakh People Who Inject Drugs (PWID). A substantial proportion of PWID report risky injecting practices. In addition, tobacco smoking and chewing are both common in India (PIB, 2019). A large, nationally-representative study of mortality in over 1.1 million homes indicates that already 1 in 5 of all adult male deaths and 1 in 20 of all adult female deaths at ages 30-69 are due to smoking and India will soon have a million smoking deaths a year (Guindon et al, 2011).

It has also been found that in general, access to treatment services for people affected by substance use disorders is grossly inadequate (PIB, 2019). Just about one in 38 people with alcohol dependence report getting *any* treatment (PIB, 2019). Only about one in 180 people with alcohol dependence report getting inpatient treatment / hospitalization for help with alcohol problems. Among people suffering from dependence on illicit drugs, one among 20 people has ever received inpatient treatment/ hospitalization for help with drug problems (PIB, 2019).

The Drug De-addiction Programme (DDAP) was initiated in 1988 under the Ministry of Health and Family Welfare, Government of India, and was mandated with provision of treatment for SUDs (Dhawan et al, 2017). Through the DDAP, de-addiction centers (DACs) have been established in government hospitals by providing a one-time financial grant by the central government, with the recurring expenses to be borne by the state governments (Dhawan et al, 2017). In addition, some premier institutions as well as DACs from Northeastern region are provided annual recurring grants for their functioning (Dhawan et al, 2017). A National Action Plan for Drug Demand Reduction (NAPDDR) has been prepared for 2018-2025, which aims at reduction of adverse consequences of drug abuse through a multi pronged strategy involving education, de-addiction and rehabilitation of affected individuals and their families (MSJE, n.d). However, there still remains a large lack of drug helplines, counselling services and interventions in the most vulnerable areas.

For more meaningful policy interventions and programs to be implemented, it is therefore crucial to understand the economics and the market of addiction, the multiple economies that function from the demand and supply side, and how to increase government interventions rather than simply depend on the private sector. The intersection between economics and addiction in general needs to be studied further (Caulkins and Nicosia, 2011). In this light, this paper will discuss the theories regarding the economics of addiction and different measures to tackle the demand for addictive goods such as taxes and government schemes and services. The paper will then discuss ways to improve treatment and rehabilitation options in India, based on the evaluation of several different policy options.

BACKGROUND

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Perhaps the most fundamental insight gained from economics is that drugs can be thought of as consumer goods, and that the demand for drugs is price inelastic (Caulkins and Nicosia, 2011). Drug consumption does obey the “Law of Demand” meaning that the higher the price, the less product people will buy. Evidence shows that even indicators associated with heavy or dependent users also respond to price, perhaps because drug use often accounts for a large share of a heavy user’s budget (Caulkins and Nicosia, 2011). For example, negative correlations with price have been documented for treatment admissions, emergency department mentions, ambulance call-outs, and urinalysis results among arrestees (Caulkins and Nicosia, 2011). Inelastic demand does not mean consumption is impervious to price; rather, it means the change in consumption is smaller proportionally than the change in price. In this case, increases in price drive up total spending on drugs, potentially exacerbating spending-related harms such as property crime and/or impoverishment of users (Caulkins and Nicosia, 2011).

Comprehensive understanding of drug markets must also consider the supply side, and economics is well-equipped to aid in that understanding. When society prohibits a substance, the supply side matters even more (Caulkins and Nicosia, 2011). Prohibition changes the nature of the problem from primarily pertaining to use and dependence to pertaining substantially to black markets and drug control. Drug markets cause enormous harms that are often ignored by cost of illness studies (Caulkins and Nicosia, 2011).

Therefore, while prohibition may not be too effective as a policy measure, taxation and price increases have shown useful results in dissuading demand and regulating the market. This has been the case in the issue of tobacco taxation. Increasing tobacco prices has been found to be the single most effective method to reduce smoking (Guindon et al, 2011). A recent study found additional evidence of the effectiveness of tobacco prices at reducing tobacco use. Increasing taxes on both bidis and cigarettes in India can be expected to have large effects (Guindon et al, 2011). As cigarettes are slowly replacing bidis as the preferred form of smoked tobacco, even independent increases in cigarette taxes can be expected to yield large reductions in cigarette use (Guindon et al, 2011). Research shows that a 10% increase in cigarette prices would reduce cigarette consumption by 3.4% in rural India, while a 10% rise in bidi prices would reduce consumption by 9.2% and 8.5% in rural and urban India, respectively (WHO, n.d). These price increases would translate to a 1.7% and 11.7% decrease in youth cigarette and bidi smoking prevalence, respectively (WHO, n.d).

The scarcity of India-specific research, the heterogeneity in methods and findings of other South Asian studies, the very limited research exploring socioeconomic differences in the impact of prices on smoking, and the complementarity or substitutability between different tobacco

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products (such as bidis and cigarettes) and between tobacco and alcohol products, calls for additional research (Guindon et al, 2011).

In addition to the schemes mentioned in the introductory section of this paper, the Scheme for Prevention of Alcoholism and Substance (Drugs) Abuse was implemented by the Ministry of Social Justice and Empowerment, in which the non-governmental organisations have been entrusted with the responsibility for delivery of services and the Ministry bears substantial financial responsibility (90% of the prescribed grant amount) (MSJE, n.d). The schemes mentioned cover demand reduction strategy, treatment and rehabilitation of addicts, awareness and preventive education, training and manpower development, etc (MSJE, n.d). There is also a focus on capacity building and training medical and psychiatric professionals.

However, the scale and scope of services under theses programs have been limited (Dhawan et al, 2017). The initially planned strategy – one-time infrastructure support from the central government and the recurring expenditure by the state governments – has met with only limited success (Dhawan et al, 2017). There is a need to continuously monitor the implementation and ensure ongoing support and nurturance to the schemes. It is high time that addiction treatment gets mainstreamed into general health care (Dhawan et al, 2017).

DISCUSSION

The economics of drug addiction needs to inform policy in a manner that makes rehabilitation and treatment something that is accessible to all sectors of society. The disparity in budget allocation and lack of implementation of government measures has led to a disproportionate number of private recovery centers, which are exclusive with better services. However, these centers do not include members of lower socioeconomic groups, which leads to a large population of people left out of the ambit of help that they desperately require. This perpetuates a cycle of lack of awareness, poverty and further drug use.

Based on this premise and lack of accessibility for poorer individuals, a scheme was developed by NDDTC, AIIMS, titled "Strengthening DDAP: Establishment of Drug Treatment Clinics (DTCs)" (Dhawan et al, 2017). Through this initiative, it was proposed that the DTC should be made functional in government health-care facilities (i.e., medical colleges and civil hospitals/district hospitals), largely utilizing the existing infrastructure (Dhawan et al, 2017). The DTC would be part of the general hospital and dedicated to provide outpatient services for patients with substance use problems (Dhawan et al, 2017).

The treatment services include psychosocial as well as pharmacological interventions. All the DTCs provide free-of-cost medication for short-term treatment of withdrawals and long-term

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pharmacotherapy (including opioid agonists, opioid antagonists, and anti-craving and deterrent medications for treatment of alcohol use disorder) (Dhawan et al, 2017). Those patients requiring ancillary services are referred to other departments of the hospital and to NGOs for social needs. DTCs also follow uniform system of record keeping of key activities and services, with periodic reporting to the regional resource centers established in select psychiatry departments of medical colleges (Dhawan et al, 2017).

In India, future requirements to meet the existing issue of addiction must also be centered around social stigma and mental health effects of the same. Social stigmatization and exclusion also has adverse effects on the economy for addiction, due to the fact that demand increases as there are no avenues for rehabilitation or social inclusion. For example, the issue of stigmatization can be seen in the treatment of those with HIV/AIDS (Alcohol Rehab, 2019). HIV is a significant issue for drug addicts in India with over 2.4 million people infected. This places India as the third-highest country in terms of rate of infection in the world (Alcohol Rehab, 2019). Injecting drug users making up nearly 10 percent of the affected groups. HIV positive drug users are often violently attacked, discriminated against, rejected by families and communities. Some HIV positive people hide their status due to fears and anxieties about being denied medical care, housing or jobs and this places others at risk (Alcohol Rehab, 2019). The increasing rate of HIV that spread throughout all communities of India alarmed the government who began on a policy of harm reduction which included needle exchange programs and maintenance therapy (Alcohol Rehab, 2019).

CONCLUSION

From the aforementioned experiences, it could be prudent from an economic perspective to implement rehabilitation programs using the public-private partnership model, to effectively address both the demand and the supply side of the market in a more everlasting manner. From an economic perspective, research indicates that is not a good measure or an effective policy in the long run to only prohibit or ban addictive products. Prohibition dramatically increases transaction costs, defined as search and information costs, bargaining costs, and policing and enforcement costs (Caulkins and Nicosia, 2011). Studies have shown that a prohibition will only lead to users spending more time, multiple times a day, trying to acquire the drug (Caulkins and Nicosia, 2011). As mentioned in the previous sections, banning products creates black markets and shifts the focus from harm reduction and interventions, to drug control which is ineffective and does not at all impact rehabilitation in a positive way.

Therefore, it is key to recognize the importance of recovery and rehabilitation centers and the need for greater state and federal budget allocation for mental health needs in this regard. While

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a considerable number of publications have lamented the lack of a coherent policy, the need for human resource enhancement and professional training and recommended a stepped-care multi pronged approach, much remains to be done on the ground (Murthy et al, 2010).

It is important for future policies to tackle drug addiction in youth, so as to discourage demand for drugs from a young age. This is also a focus on harm reduction and cultural factors rather than outright banning of products. It is much better to prevent young people from starting to use drugs than entering at a later stage and helping them give up drugs (UNODC, 2002). This is important to keep in mind because even though some programmes will aim at trying to give healthy and creative alternatives to young people who are already using drugs, it must not be forgotten that there is a whole section of the community who might start abusing drugs (UNODC, 2002). Solving this problem won't be easy either, but the solution will come in the form of better youth de-addiction centres (UNODC, 2002). In India, there is still only a small percentage of documented addiction centers that deal specifically in programs which target youth. This statistic must change if India hopes to save its youth. Policies must focus on promotion of health, encouragement of positive social interaction, encouragement of positive alternatives, and community development (UNODC, 2002).

Such an approach, along with taxation could prove to be useful. For countries, particularly low and middle income countries where health coverage is low, tobacco excise tax revenues – earmarked or dedicated, depending on political support – can provide an important source for much needed expenditure on health (WHO, n.d). Finally, it is crucial that any policy developed must be designed so that it can be implemented over the long term.

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