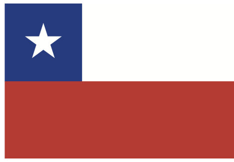
CHILE



The Burden of Mental Disorders in the Americas:
COUNTRY PROFILE

Chile is located in the southwest of South America, with acontinental and insular territory of 756,770 km² and an Antarctic territory of 1,250,000 km². The country is divided into 16 regions, 53 provinces, and 346 communes. Up to 87% of the population lives in urban areas.

Between 1990 and 2014, the population grew by 34.9%. In 1990, the population pyramid had an expansive structure in the groups over 25 years of age and a stationary structure in younger groups. It has since become regressive as a result of aging and declining fertility and mortality.

In 2019, the population was 18.9 million.
The proportion of older adults (over 60) was 14.5% in 2014. Life expectancy at birth is 77.8 years for men and 82.4 years for women.
In 2014, the per capita gross national income was US$ 21,290 (PPP).

Between 1961 and 2014, average annual gross domestic product (GDP) growth was 4.3%.

THE DISEASE BURDEN AFFECTING MENTAL HEALTH

Mental, neurological, substance use disorders and suicide (MNSS) cause 24% of all disability- adjusted life years (DALYs) and 37% of all years lived with disability (YLDs).

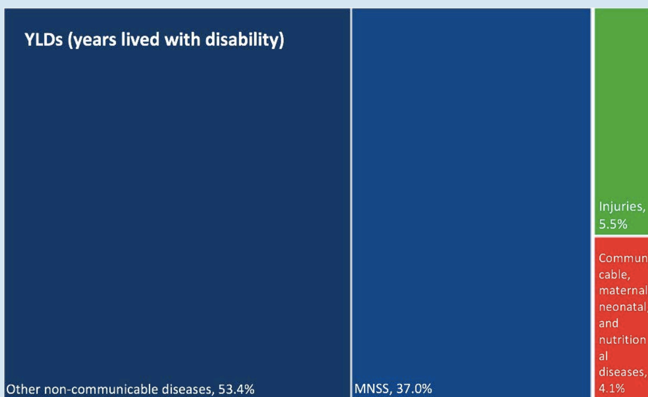


Figure 1. Distribution of YLDs with a focus on mental, neurological, substance use disorders and self harm (MNSS)

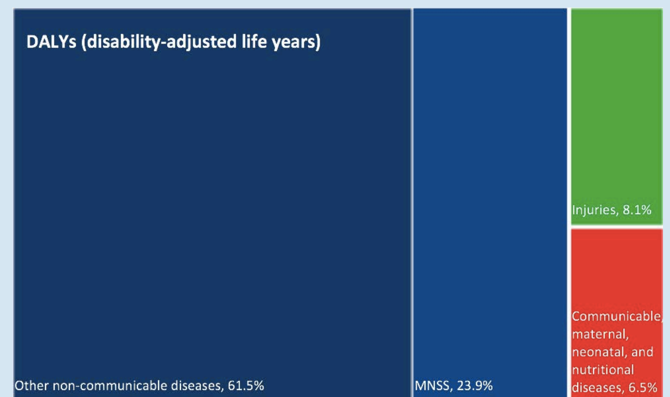


Figure 2. Distribution of DALYs with a focus on mental, neurological, substance use disorders and self harm (MNSS)

THE BURDEN AFFECTING MENTAL HEALTH ACROSS THE LIFETIME

Fig. 3 shows the changes in disease burden across age-groups. NCDs (in shades of blue) surpass 60% of the burden at 5 years old, and will remain at or above 80% from 10 years old throughout the lifetime. MNSS account for 30 to 45% of the total burden between 10 and 50 years of age, the largest burden of all disease groups during this period. Fig. 4 focuses exclusively on the burden resulting from MNSS. Before 5 years old, the MNSS burden is mostly due to epilepsy (46%) and autism (44%). Between 5 and 15 years old, the burden of anxiety disorders (24%), conduct disorders (17%) and headaches (16%) –including migraine and tension-type– gain prominence. Around 20 years of age, a pattern emerges that will remain stable throughout youth and adulthood: common disorders (anxiety, depression, self-harm and somatic symptom disorder) account for 50% of the burden, substance use disorders 16% (12% due to alcohol), headaches 16%, and severe mental disorders (schizophrenia and bipolar disorders) around 7%. The elderly suffer mostly from neurocognitive disorder due to Alzheimer's disease, which reaches 60% of the burden around 80 years old and remains above 70% after 85 years old.

This is the second installment of the 2018 PAHO report, found here

Pan American Health Organization
World Health Organization
REGIONAL OFFICE FOR THE Americas

Figure 3. Burden of disease, by disease group and age

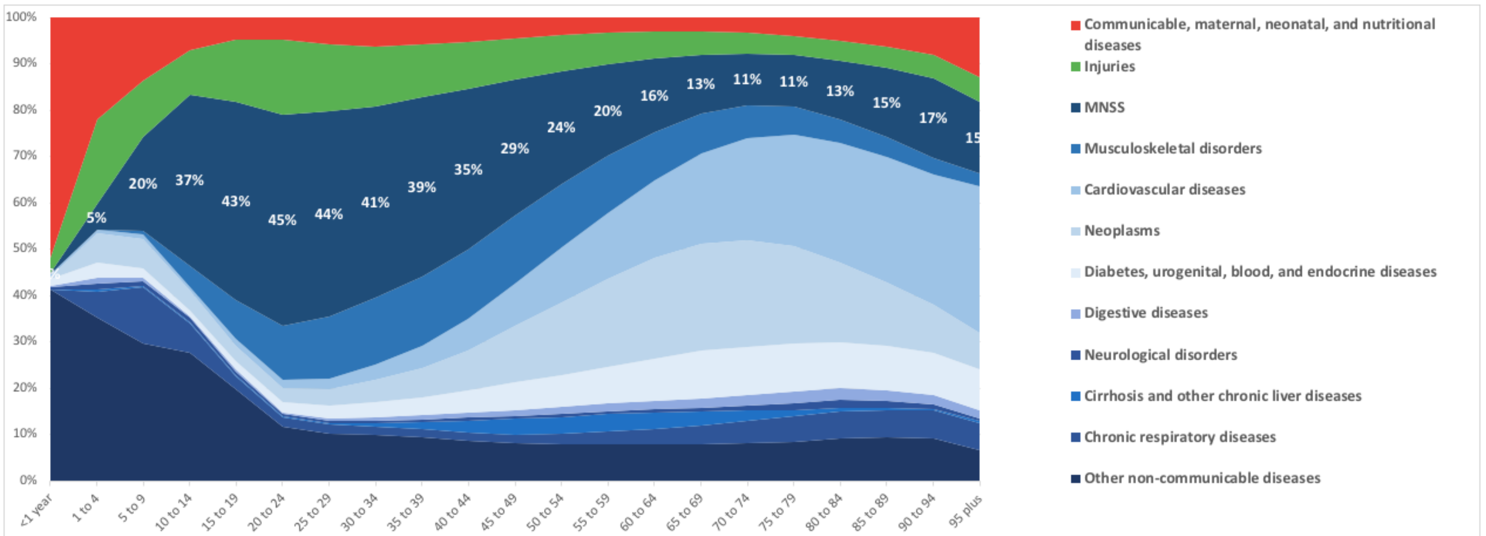
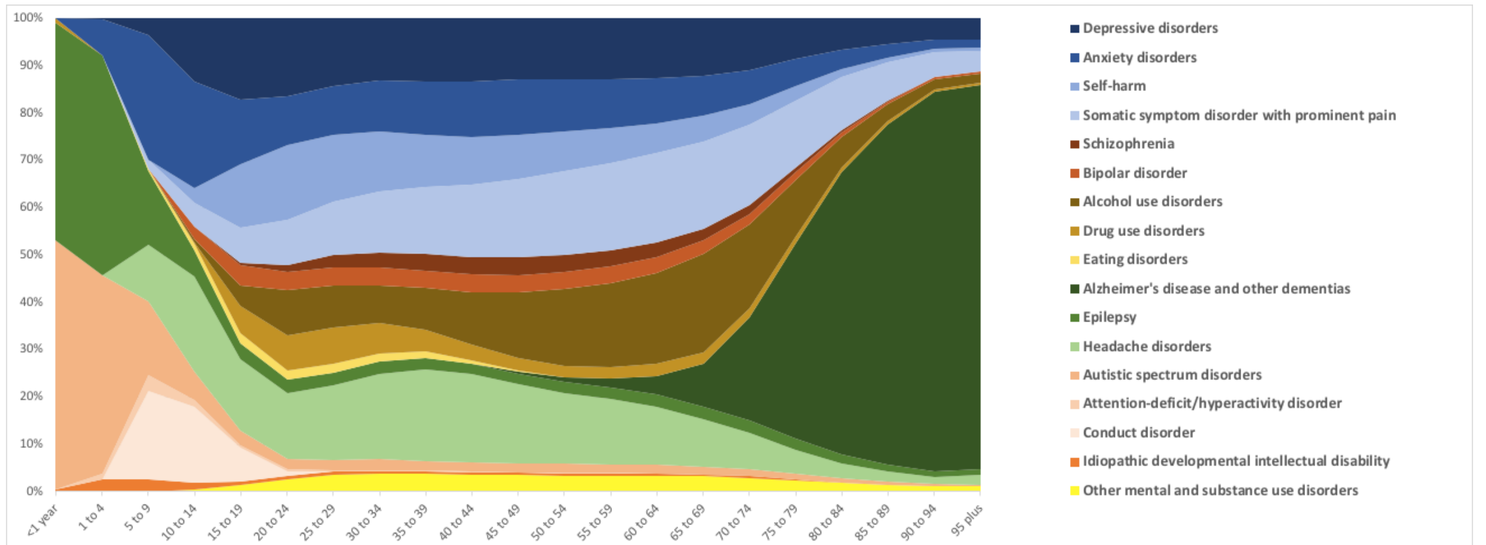


Figure 4. Burden of disease, by MNSS and age



THE BURDEN AFFECTING MENTAL HEALTH IN MEN AND WOMEN

The top three disorders in terms of disability-adjusted life-years –accounting for 45 to 55% of total MNSS burden- are not the same for men and women: While men are mostly affected by alcohol use disorders, self-harm and suicide, and somatic symptom disorder with prominent pain, women are mostly affected by headaches, depressive and anxiety disorders.

Men		Women	
Disorder	DALYs per 100 000	Disorder	DALYs per 100 000
MNSS (all)	5208	MNSS (all)	5087
Alcohol use disorders	848	Headache disorders	981
Self-harm and suicide	804	Depressive disorders	839
Somatic symptom disorder with prominent pain	655	Anxiety disorders	816
Headache disorders	517	Somatic symptom disorder with prominent pain	697
Depressive disorders	497	Alzheimer's disease and other dementias	331

Conclusions:

Considering these estimates, primary care providers should receive training and tools to prioritize detection and treatment or referral for the common disorders highlighted above for each age-group and sex. For the severe disorders –such as autism, schizophrenia, bipolar disorder and Alzheimer's– as well as for severe, comorbid, or complex presentations of other disorders –e.g. depression during pregnancy, substance use in public service professions, etc.– primary care providers and families need access to adequate supports, such as:

• Referral and/or supervision platforms that allow for continued treatment in the community, including the use of digital technology to increase access to distant geographically concentrated resources.

• Emergency, inpatient, and residential services for the management of high-risk acute situations and high-need patients. These services should be community-based as much as possible, including for crisis management, inpatient treatment in general hospitals, supported housing, and residential services.