How can mental health be integrated into health system strengthening?

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Introduction: health system challenges in resource-constrained settings

Resources for health in low-income countries, especially in the countries of sub-Saharan Africa (SSA), are extremely low compared to those in the developed world. Among World Health Organization (WHO) member states in SSA, 33 spend less than US$50 per capita per year on health, and 11 of these spend less than US$10 per capita per year (WHO, 2005). By contrast, in 2008 total health expenditure per capita in the UK and the USA was US$3,129 and US$7,538 respectively (OECD, 2010).

Coinciding with the emergence of 'accountable government', health reforms in SSA began in the 1990s to strengthen centralised, inefficient, ineffective, donor-driven and unresponsive health systems. Reforms often included the development of national policies or plans, decentralisation, an emphasis on financing and delivery of a limited set of cost-effective prioritised health interventions, and integration of targeted health programmes. Such programmes were typically funded by external donors and developed separate 'vertical' logistics, distribution, supervisory, and monitoring and evaluation systems from the centre to the periphery. Many of these health sector reforms undermined targeted disease programmes. As a response, more recently in a number of countries, donor funding, hitherto project-based, has been directed towards programme financing, pooled through government-led sector-wide approaches (SWAps) or provided as budget support.

These reforms bring both challenges and opportunities for mental health, especially their inclusion in sector policy and plans and accessing pooled funds. In spite of good evidence on the disease burden caused by mental health and the cost-effectiveness of investments in mental health, in 2005 only 59 (21 in SSA) of 185 WHO member states that provided health financing information to the WHO ATLAS project had a budget line for mental health in their ministry of health budgets (WHO, 2005). In low- and middle-income countries, where historically mental health has not been a priority, such a budget line is crucial, as without it additional government-managed funds cannot be obtained.

The financing challenge

Scarce resources elicit counterproductive competition rather than collaboration between organisations and personnel working on communicable and non-communicable diseases. It is unusual in any part of the world to find these specialisations collaborating within the health system. Although recently donors globally have committed to increases in aid to low- and middle-income countries, the global economic crisis has meant both domestic and international funding for health has declined.

We have noted earlier in this volume that mental illnesses, a key determinant of poverty, are a major source of disease burden in low- and middle-income countries. Much of this morbidity and mortality is potentially avoidable but largely overlooked, unlike major communicable diseases such as HIV, malaria and tuberculosis, which have rightly benefited from substantial international financing since 2002.

International and domestic health policy-makers, faced with many conflicting demands, prioritise a few disorders rather than taking a comprehensive public health approach. Disease priorities have historically been influenced by mortality data, but such mortality data ignore co-morbidities and do not account for the fact that poor mental health is a trigger for premature mortality from physical health disorders. Increased rates of HIV and tuberculosis are found in those with mental health problems, and those affected by HIV and tuberculosis suffer a higher burden of mental illness.[2,3]

It is clear that resources from international organisations remain limited, although the Department for International Development (DfID) is spending about 10 per cent of its health-related budget on mental health activities.

Financial constraints also arise from mental health not being prioritised in national or sectoral plans. Consequently, in 70 per cent of SSA countries, for example, financing allocated to mental health is below 1 per cent of the health budget, despite poor mental health accounting for over 8 per cent of the disease burden (WHO, 2005). In countries where the annual per capita allocation for health ranges from US$8 to US$12, this will not be adequate to develop a national mental health programme, let alone implement continuing professional education, support supervision, monitoring and evaluation, and ensure that the key central functions of a mental health unit are to be found within the Ministry of Health.

Health system factors that constrain or enable delivery of mental health care

Mental health is an intersectoral issue, with interventions required in education, social welfare, criminal justice systems and the non-governmental organisation (NGO) sector. Nonetheless significant inputs are needed from the health sector to address mental health problems. However, in low- and middle-income countries, the health infrastructure to address these needs is highly limited. For example, Tanzania has 13 psychiatrists in the public sector for a population of 32 million, while Kenya has 16 psychiatrists in the public sector for a population of around 30 million (WHO, 2005). Both Kenya and Tanzania each have around 200 psychiatric nurses, but these numbers are falling rapidly with movement out of mental

Picture courtesy of Lesley-Jo Weaver

Isolated settlements (pictured, India) call for multi-skilled primary healthcare workers

health care to more lucrative programmes, as well as because of retirement and mortality.

With good assessment, diagnosis, a management plan and sustained follow-up to full recovery, people with depression and anxiety can mostly be treated at primary care level. A small proportion will not respond well and will require referral to district level. Although in the West all new clients with psychosis are referred to specialists, in low-income countries there are too few specialists for this to be the norm (for example, a 1 per cent population prevalence of psychosis and less than one psychiatric nurse per district of between 100,000 and 250,000) As a result, most people with psychosis are attended to by primary care staff or traditional healers and only a small proportion are seen by specialists, with children with mental disorders mostly missed and ignored except in the private clinics of the capital cities.

For effective implementation, mental health policies should be developed separately but well integrated into health, social and educational policies and strategic action plans. Similarly, mental health needs to be integrated into national annual operational plans and the national essential package of health interventions. But in practice such integration is difficult and requires strong advocacy, encouragement by major donors and support from relevant ministers or local champions, as well as civil servants inside ministries of health able to achieve the practical integration into the relevant official documentation.

For example, in Kenya, a primary care training project funded by the UK NGO the Nuffield Trust allocated additional funds to build psychiatric nurses' capacity to conduct such advocacy, and give them planning and budgeting skills. This led to increased numbers of districts incorporating mental health into their district annual operational plans.[4] In Uganda, the WHO, the Ministry of Health and other bilateral donors support annual meetings of District Mental Health Co-ordinators so that they are able to plan, budget, implement and monitor their programmes, thus accessing district level and national level funds.[5]

Integration of mental health data into routine health information systems

Mental disorders or health in most low- and middle-income countries are not adequately captured in routine health information management systems (HIMS). While donors and countries ask for data to demonstrate outcomes and value for money for mental health investments, funding to incorporate mental health into HIMS is all but absent. For example, in Kenya and Tanzania, data from primary care facilities are collected for 36 physical health diagnoses, but all mental disorders are included as one diagnosis, thus reducing the utility of this data for planning purposes.

In Uganda, several categories of mental disorders have been added to the HIMS form: depression, anxiety, manic illness, schizophrenia,

alcohol and drug abuse, childhood mental disorders, epilepsy and 'others'.[6,7] This is good progress, but for a good core data set, around 14 categories are needed for planning purposes, to include depression, anxiety, bipolar disorder, schizophrenia, childhood conduct disorder, childhood emotional disorder, attention deficit disorder, autism, post-traumatic stress disorder, dementia, toxic confusional state, learning disability, alcohol abuse and drug abuse. Furthermore, diagnosis of mental disorders at primary care level is often likely to be inaccurate, underestimating the disease burden. For example, a recent survey in ten districts of Uganda using the 12-item General Health Questionnaire (GHQ-12) as part of the exit interview for people in outpatient and antenatal clinics showed that up to 30 per cent of those interviewed identified themselves as having a mental disorder, confirmed by high scores on the GHQ-12. However, the HIMS data only captured a minuscule number of these cases.

Physical resources

Limited availability of physical resources is a major constraint to service delivery and development of policies to address the infrastructure gaps. This is especially true for SSA countries that retain ageing, ex-colonial psychiatric institutions (often on the edge of capital cities). These under-resourced structures, which nonetheless take up much of any available funding for mental health, are now severely run down. Hence, governments face the challenge of choosing between prioritising scarce mental health resources for investment in the rehabilitation of old and obsolete structures, an option often driven by the consultant psychiatrists who run these hospitals, or for building district-level decentralised units that are more accessible to the population. Policy shifts that favour decentralisation are difficult to achieve as they require not just additional new resources but also substantial political commitment from government, as well as commitment from psychiatrists and other specialists who would have to relocate away from hospitals in capital cities in order to provide more equitable access to care.

In Uganda, with the support of the African Development Bank, the 970-bed National Psychiatric Hospital has been downsized to 450 beds and 12 regional referral units have been built across the country. This has taken a ten-year commitment from the Government of Uganda, with the support of a loan. In Tanzania, the 1,000-bed National Hospital at Dodoma has been downsized to between 400 and 500 beds, with the development on site of a major training centre for psychiatric nurses and medical officers. Similarly, in Kenya, the 1,000-bed National Hospital on the edge of Nairobi was downsized. However, in both Kenya and Tanzania, demand pressures due to an increased prevalence in severe substance abuse is pushing up bed numbers again. This recent reversal in patient flows to such national hospitals could be avoided with better implementation of prevention policies and earlier detection and treatment at primary care level, together with the inclusion of small inpatient units in local district hospitals.

Resource allocation is inextricably linked to the availability of financing. Frequently, the limited budget allocated to mental health units is utilised at the central ministry level and by the national psychiatric hospital; little is available for primary care level services where the vast majority of people with mental health needs can be reached. While it is important for mental health to be integrated into primary health care, this also raises a further challenge in terms of how to ensure that within a package of essential healthcare services, sufficient resources are targeted towards mental health. While it is assumed that primary healthcare staff will provide mental healthcare services and requisition appropriate mental health medications in the normal way, as well provide support, supervision and outreach services, in reality widespread stigma towards mental health means that mental health needs are often excluded from provincial and district planning processes. These issues need to be addressed if mental health services are to be adequately delivered within primary care. There is also a need for studies that track the financing pathways, quality and access to mental health services in provinces and districts, in order to help with future planning and resource allocation.

Human resources

Health workforce capacity, both in terms of numbers and skill sets, is another major policy challenge. In most SSA countries, health workers at the primary health care level range from general nurses and clinical officers (medical assistants with three years of medical training) to health workers with little or no formal training. Tanzania, Kenya, Uganda and Malawi have nurses and clinical officers at primary care level. In addition, Kenya, Ethiopia and Uganda have community or village health workers who are given short episodes of training so that they can extend the reach of primary care to the community. These community or village health workers generally play a role in encouraging vaccination and reproductive health programmes, but are also being trained to recognise clients with common mental disorders, helping to identify those with side effects as well as those in remission, and then referring individuals to health centres as appropriate. In Ethiopia, the health extension worker programme has been challenged by high attrition rates, but in Kenya specific training and supervision by community health extension workers is further strengthening the community health worker programme.

Capacity is also an important issue at the policy and planning level centrally, as well as at both district and provincial levels, where there is potential for mobilising additional resources from district and provincial budgets. For example, in Kenya, the primary care training programme funded by the Nuffield Trust has trained provincial and district specialist staff in advocacy and planning so that they can better access provincial and district funds.[8–10]

While there are good examples of interventions to address policy challenges, many challenges remain and are unlikely to be resolved soon unless new additional domestic and international financing is allocated to mental health. International stakeholders, including the United Nations and the World Bank, government overseas aid programmes and major third sector groups can play a key role in fostering investment and interest in mental health. They can also do more to help address ongoing challenges experienced in many low-income countries, including the challenge of training and retaining healthcare workers in a labour market where skilled workers are also being attracted by opportunities in high-income countries.

Conclusion

A number of actions are necessary to effectively address these health system bottlenecks to delivery of mental health care in order to counter the high prevalence of mental disorders, to build mental

capital at individual and population level to avoid the burden of mental disorder as much as possible, and to prepare health systems for projected increases in mental disorders resulting from demographic change.

- Better integration of mental health into general health policy and essential healthcare packages.
- Health systems research to demonstrate the costs and effectiveness of basic mental healthcare packages in different countries and the effectiveness of interventions to address mental disorders.
- Better identification and use of levers and entry points, to enable increased participation of mental health professionals and stakeholders in health sector reforms.
- Policy actions to strengthen the linkage between mental health, public health and intersectoral policies.
- Enhanced involvement of civil society and the community in needs assessment, planning and delivery of mental health.
- More effective resource mobilisation strategies to address gaps in financing.

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Endnotes

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