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Editorial

Scaling up mental health services: where would the money come from?

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This editorial and accompanying article are the second in a series of four articles and editorials about the central importance of including mental health in global development policy and practice. The first article set out some of the core concepts and summarised the current state of knowledge on key mental health issues.[1] The article below addresses social, economic and political challenges to addressing the burgeoning burden of mental illness in low- and middle-income countries. Later articles in this series will address in detail international and national policy challenges and solutions to them[2] and health system challenges and ways in which these can be effectively addressed;[3] while their accompanying editorials will highlight key issues for policy makers from a public policy perspective.

At a time of global recession, it is particularly challenging to argue for new additional funds to be invested in addressing mental illness in low- and middle-income countries, especially as some donors often see such investments as unaffordable luxuries. For example, Nigeria's health budget for 2010 to 2011 was reduced by 45% (personal communication from the Ministry of Health) – a situation not uncommon across the globe, in richer countries as well as poorer ones.

The commitment of rich countries to assist poorer countries in alleviating poverty remains a key Millenium Development Goal (MDG) adopted by the United Nations. While the global economic crisis has led many donor nations to reduce their Overseas Development Assistance in 2010,[4] the UK has maintained its commitment to reach 0.7% of GDP in overseas aid by 2013.[5] Strong associations between mental health, income, low education, poor housing and debt suggest that efforts to lift large populations out of poverty should at least pay some attention to mental health and mental disorders.

A barrier to implementing interventions in low-income countries is the relative paucity of studies on their cost-effectiveness, and a lack of analytical work assessing the opportunity costs of not intervening. This paucity of evidence in low- and middle-income countries contrasts with strong evidence from high-income countries on a range of cost-effective interventions and studies which clearly demonstrated human and socio-economic cost of inaction. The lack of evidence from low- and middle-income countries has created a barrier to securing commitment from donors and policy makers in such countries. But without funding, research studies to

generate new contextually relevant evidence cannot be undertaken. This vicious circle needs to be broken. The second article in this series[6] therefore addresses some of the problems in this area.

The concern for extremely limited international funding to address mental disorders in low- and middle-income countries is not new, as evidenced by the steady and concerted effort on mental health advocacy over the last two decades (see Box 1).

The information used for advocacy, targeting policy makers on mental health, includes epidemiology,[17,18] disease burden, links with physical health,[19] links with the economy,[20] links with other development targets,[21] human rights concerns[22] and issues of equity and fairness.[23–27]

However, in spite of the growing evidence base on the importance of mental health globally, the case for prioritising mental health is not obvious to many policy makers. Clearly, along with more research better communications strategies are needed to raise awareness of the potential benefits to be gained by investing in this neglected area. However, funding for mental health research in low-income countries is all but absent. This will probably delay prioritisation of mental health as an area worthy of investment, with consequent adverse effects for both mental and physical health. There are lessons to be learned from the cost of inaction in relation to tobacco; international and public sector action on tobacco was decades late in spite of scientific knowledge about its adverse health and socio-economic impacts.

A further barrier to mobilising international and domestic resources for mental disorders is that senior mental health professionals do not always have the requisite public health skills for effective national advocacy, policy making, planning or financing, and very few work in senior positions within ministries of health. The few who have senior positions within ministries of health typically lack the necessary skill sets to meaningfully engage in discussions on the broad public development agenda and those pertaining to health systems reform. Hence they are usually not able to influence policy or take advantage of funding opportunities for new initiatives.

While the World Health Organization has made efforts to address this knowledge and influence gap, policy making still remains out of the reach of mental health policy makers. The policy discourse is often dominated by health policy makers used to dealing with 'physical' rather than 'mental' health problems, who determine Ministry of Health priorities and agree these with Ministry of Finance officials. If mental health is to access new funding, close engagement is needed at local and global level with policy makers dealing with communicable and non-communicable illnesses beyond mental health. There need to be efforts to include mental health in international and domestic meetings involving policy makers, programme implementers, public health

Box 1 A history of international advocacy for mental health

- 1992 Start of World Mental Health Day and commitment of First Ladies around the world (WFMH and WHO)
- First Ladies regional meetings in mid-1990s with signed declarations of support for mental health action, initiated by the Carter Centre and Roslyn Carter (Carter Centre)
- 1995 Desjarilas *et al* launched at UN in presence of Boutros Boutros Ghali[7]
- 1996 Global Burden of Disease Study[8]
- 1997 WHO Nations for Mental Health Programme, with demonstration projects
- 1998 WHOCC seminar for senior World Bank staff
- 1999–2006 appointment of mental health secondee to World Bank, and a series of further mental health seminars held in the World Bank for senior bank staff
- 1999 WHO Collaborating Centres (WHOCC) run World Federation for Mental Health 50th anniversary conference in London in partnership with the WHO, with endorsements from Kofi Annan, World Bank, Queen Elizabeth II and the UK Prime Minister
- 2001 World Health Report[9]
- 2001 *Neurological, Psychiatric, and Developmental Disorders: meeting the challenge in the developing world*[10]
- 2002 Developing a National Mental Health Policy[11]
- 2005 Declaration of Helsinki[12]
- 2007 Lancet series on mental health[13–15]
- 2002, 2004, 2006, 2008 WHOCC seminars for the Department for International Development on mental health
- US National Academy of Science Brain Disorders Meeting in Uganda[16]

professionals, economists, health sector specialists and civil society. A clear communication agenda to demonstrate the benefits of investing in mental health in terms of improved physical health and reduced socio-economic burden, and a case being made for the importance of this investment in reaching the MDGs – given the inextricable link between mental health and AIDS, tuberculosis, malaria, child cognitive and education development and poverty – is essential.

These communication efforts need to be combined with investments aimed at capacity building for senior officials from Ministries of Health and Finance so that they may better compile and present the available evidence and formulate clear recommendations for the inclusion of mental health within health agendas. But most important of all, the global efforts aimed at improving human rights and achieving universal access to interventions for communicable and non-communicable diseases must factor in the unacceptable burden and human rights abuses associated with mental illness.

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CONFLICTS OF INTEREST

None.

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