

ODI Insights

How low-income countries can invest in mental health

Jessica Mackenzie and Hannah Caddick

This policy brief provides an overview of research by the Overseas Development Institute to make mental health provision realistic and manageable for low-income countries (LICs). Mental health represents a huge cost to society and the economy in healthy years lost and affects some of the world's most vulnerable people. It is also now included in the Sustainable Development Goals. But while the need to invest in mental health is increasingly recognised, funding is still not being prioritised. Part of the problem is that the expert-recommended minimum spend on mental health is around ten times what LICs are currently spending on average. This research found that there were valuable steps that governments can take with limited funding, and suggests an incremental approach to both investment and service delivery.

Governments should:

1. **allocate spending for mental health** in national budgets and request funding for mental health from donor governments and via other funding mechanisms
2. **increase funding gradually** to improve coverage for mental health care in low-income countries, and scale up over time
3. **consider using a community-based stepped care model** to increase service coverage while resources and expertise in-country build
4. **conduct national assessments** to better understand country need, take stock of existing services and identify the scale of the change needed.

ODI Insights is a series of research papers, policy briefings and outreach activities that address urgent and unresolved development priorities and challenges. As well as reaching new audiences, the aim of Insights is to ensure that ODI's high-quality research and analysis influences policy debates and provides innovative solutions to bring about practical change.



The issue

Despite increasing recognition around the globe of the need to invest in mental health, funding is still not being prioritised – in national budgets or in development aid for LICs. Previous research by ODI suggested that donors would be willing to provide funding to LICs for mental health but that demand needed to come from the LIC governments themselves (Mackenzie and Kesner, 2016).

For policy-makers in LICs, grappling with complex and urgent competing priorities, engaging with mental health programming may appear opaque and politically sensitive, not to mention financially out of reach (Mackenzie and Kesner, 2016). One major barrier to prioritising funds, cited by decision-makers during previous consultations, was a lack of understanding of *how much* and *how* to spend money on mental health.

At an expert roundtable discussion in May 2016, it was revealed that in physical health, presenting decision-makers with a ‘menu’ of costed options and activities had worked well to get them to prioritise funding. This research set out to see if the same could be done with mental health, ultimately to make investing in mental health services realistic and manageable for LIC governments. Our hope is, that by doing so, governments will be better able to allocate funding, as well as leverage further financing from donors.

The research

This research builds on two prior ODI reports (Mackenzie, 2014; Mackenzie and Kesner, 2016). It draws on programmatic work with the Mental Health Innovation Network in several countries from 2014-2016; an expert roundtable hosted at ODI in May 2016; extensive personal communication with, and calculations by, World Health Organization (WHO) health economist Dan Chisholm; and a series of semi-structured interviews with leading practitioners in the field. The research also draws on the extensive analysis conducted by the WHO, the London School of Hygiene and Tropical Medicine, Grand Challenges Canada, *The Lancet*, DCP3 series, BasicNeeds, and other pioneers in global mental health evidence. Given that global data on mental disorders are incomplete, and under-diagnosis remains a problem, the analysis presented here is necessarily based on averages and extrapolations.

Within the scope of this research, this policy brief and accompanying working paper, aims to present realistic and manageable options for LIC governments to increase mental health service provisions and looks to stimulate further research and analysis in this area.

By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and wellbeing.

Sustainable Development Goals, Goal 3, Target 4

Research findings

Four key findings have emerged from the research:

1. It is possible to take an incremental approach to improving coverage for mental health care in low-income countries.

Reviews of literature on both mental health and physical health, and interviews with leading experts in mental health service delivery in low-income countries, reveal valuable first steps that governments can take with limited funding. Over time, and with increased financing from donors, or by prioritising it in national budgets, governments can scale this up in a planned and systematic way to increase service coverage (the number of people accessing treatment). Through this research, we devised three costed service packages (Box 1 and Figure 1), starting at \$1 per person per annum (pppa), and rising to \$3 pppa. While \$1 pppa is well below expert recommendations and would be a mediocre short-term goal, it represents a significant increase on what is currently being spent in LICs and a realistic, minimum package of care with reasonable coverage levels for those people with unmet, urgent needs.

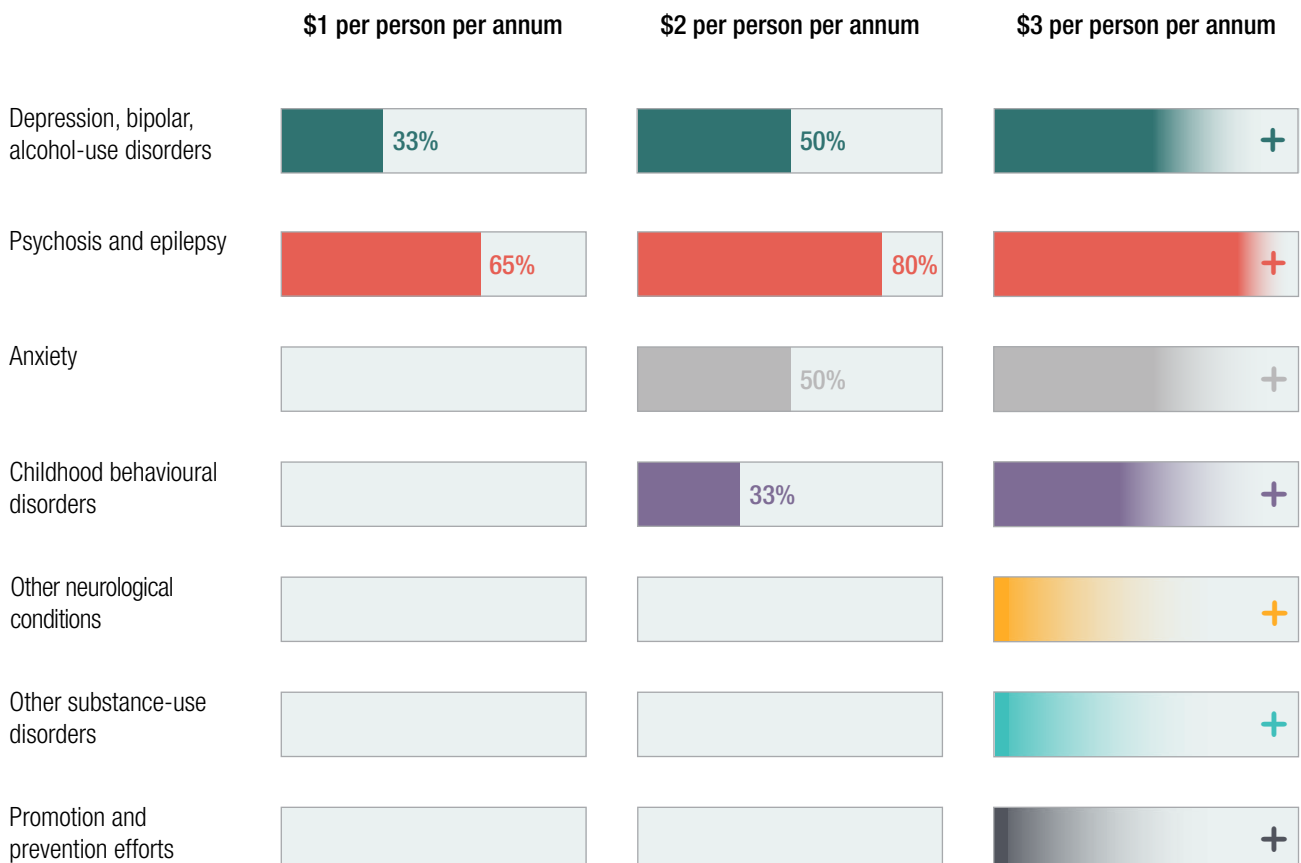
Box 1: Costed service packages

\$1 per person per annum could deliver treatment to 22% of the affected population. This is by no means adequate and is included only as a stepping stone to higher spending.

\$2 per person per annum could deliver treatment to 49% of the affected population – the minimum level of coverage that experts recommend. Selecting this care package could enable governments to reach the desired target coverage levels specified in the WHO Mental Health Action Plan.

\$3 per person per annum could deliver treatment to 75% of the affected population. It would also include augmented promotion and prevention efforts, such as awareness and anti-stigma campaigns, and school-based programmes. This is what governments should be aiming to provide.

Figure 1. Estimated coverage by disorder type



2. Gains for low-income countries are potentially huge.

If governments increased mental health spending to the expert-suggested minimum of \$2 pppa, close to 13,000 healthy life years (the number of years an individual spends in a healthy state), could be gained each year for every million population. This would not only improve the situation of individuals – good health and a long life are fundamental objectives of human activity – but it would also lead to economic benefits. It would lessen pressure on public health care and increase the possibility that people could work, thereby contributing to economic growth. In monetary terms, countries spending \$2 pppa could see returns to the economy of \$4.26 million per million population (see Box 2).

Importantly, health improvements also have a social value; conceptually distinct from improvements in clinical functioning and the restored ability to do paid work, the successful scaled-up treatment of mental disorders such as depression and anxiety can also lead to improved opportunities for individuals and households to participate in more social and community activities, carry out household production roles and pursue their leisure interests. Increasing spending to \$2 pppa would also help countries meet their commitments to increasing coverage, as set out in the WHO Mental Health Action Plan 2013-2020, and Sustainable Development Goal (SDG) 3, Targets 4, 5 and 8.

3. Striking a balance between coverage and quality.

International estimates such as the Global Burden of Disease (GBD) studies suggest that there are several common mental health disorders that should be addressed because of their widespread contribution to the burden of disease and the availability of cost-effective and scalable interventions.

However, it would be wholly unethical (and unproductive) to fail to treat certain disorders, and there are differing levels of severity. For example, although schizophrenia is associated with low prevalence compared to anxiety and depression (which typically have high prevalence rates), it could be considered a more severe condition because it is highly disabling, it occurs at a young age and it pushes households into poverty.

Instead, the aim should be to increase service coverage across both severe and common mental health disorders (Figure 1). And there are models of care, such as the community-based stepped care model (Figure 2), that can do this while a country builds up the necessary expert skills to sustainably address mental health needs.

Box 2: Welcome to Nesamania

The fictional country of Nesamania has a population 10 million, and a per capita GDP of \$600. What would it look like if the government increased investment in mental health?

If the country increased spending on mental health to \$1 pppa, it could see yearly economic returns (based on the return healthy life years to the population) of \$1,500,000 per million population. If it increased spending to \$2 pppa, returns could be as high as \$3,900,000 per million population.

With a population of 10 million, *Nesamania* could see a total annual economic benefit of \$15 million or \$39 million, respectively. Subtracting what the government will have invested to get there, net returns might be as high as \$19 million in a single year.

Box 3: Four steps to implement mental health care action plan

1. Know your domestic mental, neurological and substance-use disorder needs (*estimated 0.1-2.5% of mental health funding*)
2. Know your domestic mental health assets (*estimated 0.75-1.0% of funding package*)
3. Implement a community-based model, linked to trained professionals, which is scalable. (*estimated 80-95% of funding package*)
4. Integrate mental health into existing development priorities (*cost-effective, but cost will vary*)

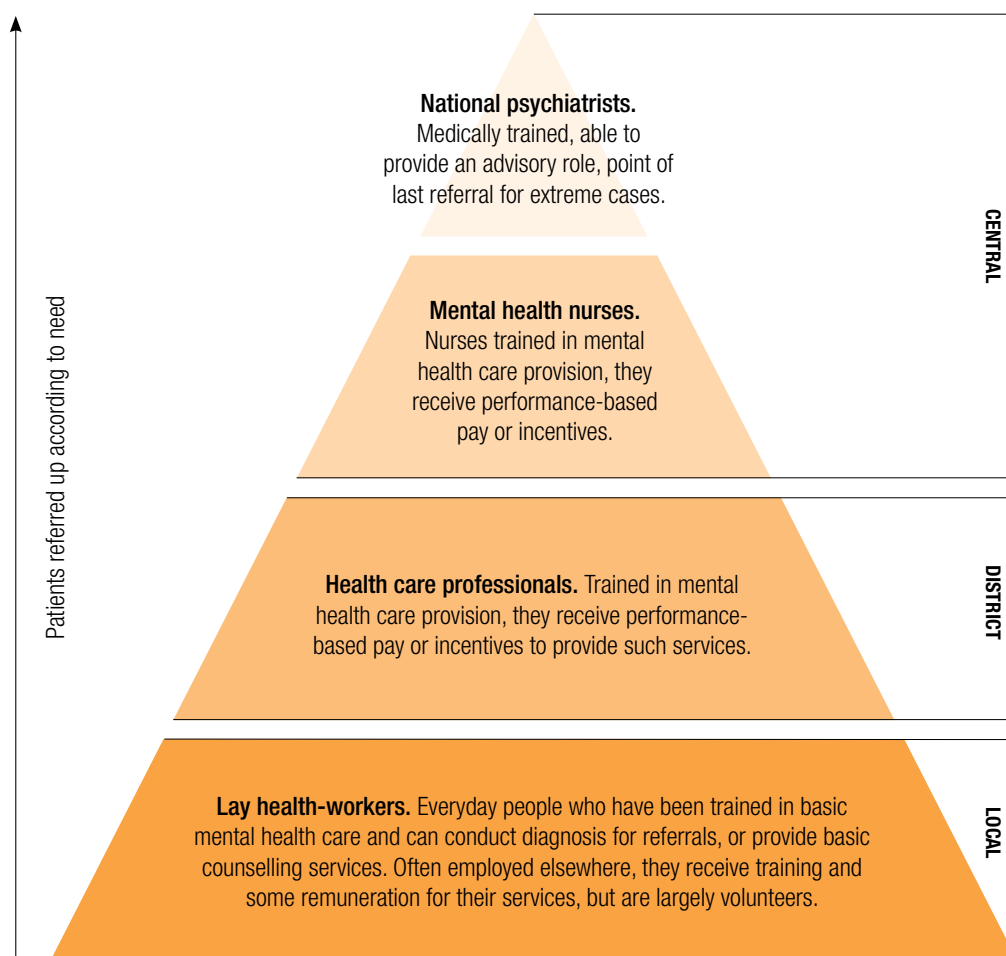
In all these steps, a monitoring and evaluation component should be included, recognising that increasing a country's health system capacity takes time and requires continual reflection on investment and returns.

4. Accurate budgeting and mental health planning requires national and sub-national consultation and assessment.

While there are good estimations of costs and treatment models provided by WHO, GBD studies and other mental health pilots and programmes, the situation of every country will be different. First, different countries – and regions – will have higher or lower incidence of different mental health disorders, depending on a variety of factors. And while coverage across both common and severe disorders should be the ultimate focus, prevalence will help identify priority needs. Some work has already been done in this area: for example, the Programme for Improving Mental Health Care study identified the priority mental disorders in five low- and middle-income countries (LMICs) as psychosis, depression, epilepsy and alcohol-use disorders, but each country should ideally conduct its own prevalence assessment.

Second, the cost of delivering treatment varies between different countries and regions, depending upon the costs of services in-country, how remote the regional areas/populations are, and factors like the condition of existing infrastructure and availability of drugs. Though research into predicting all of these factors is been limited, there are several national- and district-level studies (such as, Gureje et al., 2007 and Chisholm et al. 2015) that have assessed costs for service delivery across a range of LMICs in both Asia and sub-Saharan Africa. Finally, there may also be other country priorities into which mental health fits (for example, improving uptake of HIV treatment by reducing depression), which may influence investment in these areas.

Figure 2. Community-based stepped care model



Policy recommendations



1. Allocate mental health funding

Given the potential benefits from investing in mental health, governments should make funding it a priority in their national budgets, and should request this funding from donor governments and via other funding mechanisms. It is possible to demonstrate these returns, to taxpayers and to donors, in terms of healthy life years gained, GDP increases, people in work and reduction in suicides. There are international and national targets and baselines, to guide investment and measure progress, as set out by WHO.

There is also value in tracking and reporting on funding for mental health. This means countries can show they are progressing against the WHO Mental Health Action Plan 2013-2020, and towards achieving SDG3. Tracking of mental health funding is currently incomplete and inconsistent at best (and at worst, non-existent).

If countries can explicitly demonstrate that mental health is a local priority, it may attract more support from the wider donor community. Our consultations found that donors would be prepared to invest more in mental health programming, but that the demand would have to come from country governments.



2. Increase spending gradually

The gap is not insignificant and governments are dealing with competing priorities. Low-income country governments are currently only spending around \$0.20 per person per annum on mental health. The expert-recommended spend of \$2-\$3 pppa is 10-15 times this current spending, and represents a huge increase for governments with limited budgets and many competing priorities.

We have devised three costed service packages that LICs could use to structure their budgets and service delivery planning. The service package chosen will depend upon available resources and the level of ambition of the policy-makers, but the packages should be viewed as incremental steps to improving mental health care, not finite goals in themselves.

Minimum spending on mental health in LICs should be somewhere between \$1 and \$3 per person per annum (Gureje et al., 2007; Patel et al., 2015; Chisholm et al., 2015; 2016b). One dollar would be a mediocre short-term goal, and well below expert recommendations. Though still inadequate, it represents a realistic, minimum package of care with reasonable coverage levels for those people with unmet, urgent needs. Recognising the time required to increase health system capacity, this could then be increased incrementally, to \$2 pppa, \$3 pppa, and more, as investment begins to yield returns and capacity in-country increases.



3. Consider a community-based, stepped care approach

A community-based stepped-care model is the most widely recognised way to reach people who need mental health services, sensibly and with limited resources. This model is the basis of several effective programmes in the NGO space – including BasicNeeds, Community Care for People with Schizophrenia in India, and MANAshanti Sudhar Shodh, all of which are delivering impressive results for low cost. The approach is believed to generate population health benefit – that is, it may benefit groups of people rather than just individuals. Furthermore, it can reduce stigma by helping the broader community understand mental illness and how it can be addressed.

It is a strong cost-effective model for governments to use. A stepped care model is a tiered programme (Figure 2). It is based on having a few select trained medical specialists at the top (however many qualified, operating psychiatrists are available in country); some nurses and health professionals trained in mental health care throughout the national system; and finally, a broad base of people willing to be trained by professionals to help deliver basic mental health services. These people (often called lay health-workers), once trained, are able to diagnose, refer and provide basic mental health services such as counselling, for the population. They would

require remuneration for their work, but it need not be expensive. This model is likely to be cost effective, because the least intensive intervention that is appropriate for a person is typically provided first. The idea is to use front-line, non-specialist health workers to identify and treat mental illness at a national level, as a means to counter the large treatment gap in LICs.



4. Conduct national assessments

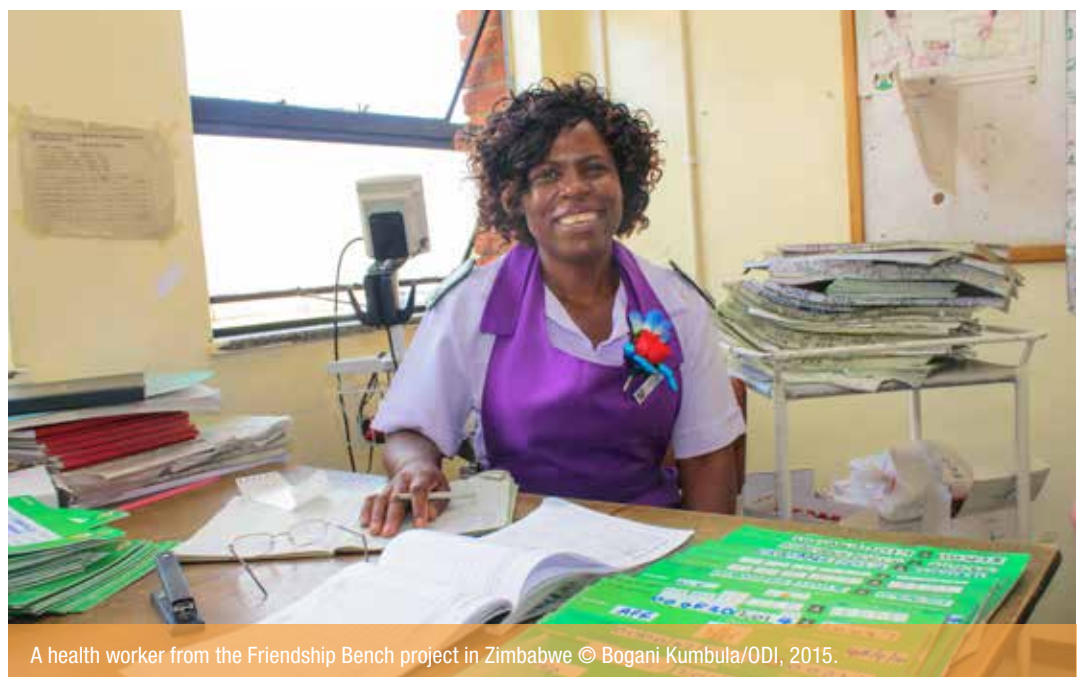
Policies should be enacted and resources allocated according to specific individual country needs.

Each country is different, and each country will want to make its own decisions. It is therefore necessary for more economic evidence to be generated alongside clinical trials or other evaluations at the national level (see the steps outlined in Box 1), rather than relying on international estimates that may lack sensitivity to local priorities or health system characteristics.

Governments should undertake a prevalence assessment to better understand which disorders to prioritise in increasing service coverage.

This doesn't have to be expensive, but it is crucial. Conducting a prevalence assessment will help governments understand the scale of the problem and therefore the levels of investment needed. It will also ensure that approaches are based on real evidence and are directed at those who are most in need. Given these cost around 0.1% to 2.5% of the funding that countries would be spending if they were to meet expert recommendations, this seems a modest investment to ensure spending is targeted correctly.

Governments should do a 'stock-take' of existing services and what's working. 'What's working' can be tricky in mental health, because it's not always as simple as 'curing' someone; often it is about managing an ongoing disorder, or allowing an individual and their family to maintain a certain quality of life. Treatment choices are also difficult, and best-practice guidance should be sought from national and international health practitioners. Typically, a combination of talking (or signing) therapies and drug-based interventions works best, though the same combinations of treatment won't work for every individual, or in every context. The cost of services and treatments varies across countries (and sub-national areas, depending on terrain and infrastructure), and so we can only estimate what certain spending will deliver. Some work has already been done in this area by WHO.



A health worker from the Friendship Bench project in Zimbabwe © Bogani Kumbula/ODI, 2015.

Conclusion

For governments to even spend \$1 pppa amounts to five times the current average LIC spending on mental health. For this reason, we have devised the incremental packages that build the spending in a more realistic way for governments.

The graduated nature of these packages means that there is space for policy-makers to begin with the lowest increment and increase their services as local circumstances and capacities adjust. Countries should remember that the \$1 package is well below expert recommendations and not nearly adequate, and we encourage them to progress to the \$3 package as soon as possible. Beyond the very valid social, humanitarian and normative rationales, there is an excellent economic argument that cannot be overlooked – most of all in the poorest economies in the world. An annual investment of a few dollars per person for mental health services, could deliver impressive returns.

We hope this outline will be helpful for policy-makers wondering how to invest in mental health and why it might be worthwhile from a development perspective. For those seeking more information on the details of implementation, we encourage you to tap into the wealth of existing resources in this field. And for those willing, we urge you to invest in this important area.

References

- Chisholm, D., Sweeny, K., Sheehan, P., Rasmussen, B., Smit, E., Cuijpers, P., and Saxena, S. (2016). 'Scaling up treatment of depression and anxiety: a global return on investment analysis', *The Lancet Psychiatry* 3(5): 415-424.
- Chisholm, D., Burman-Roy, S., Fekadu, A., Kathree, T., Kizza, D., Luitel, N., Petersen, I., Shidhaye, R., De Silva, M. and Lund, C. (2015) 'Estimating the cost of implementing district mental healthcare plans in five low- and middle-income countries: the PRIME study', *British Journal of Psychiatry* 208(Suppl. 56): s71-78.
- Chisholm, D., Flisher, A.J., Lund, C., Patel, V., Saxena, S., Thornicroft, G. and Tomlinson, M. (Lancet Global Mental Health Group) (2007a) 'Scale up services for mental disorders: a call for action', *The Lancet* 370(9594): 1241-1252.
- Chisholm, D., Lund, C. and Saxena, S. (2007b) 'Cost of scaling up mental healthcare in low- and middle-income countries', *British Journal of Psychiatry* 191(6): 528-535.
- Gureje, O., Chisholm, D., Kola, L., Lasebikan, V. and Saxena, S. (2007) 'Cost effectiveness of an essential mental health intervention package in Nigeria', *World Psychiatry* 6(1): 42-48.
- Mackenzie, J. (2014) *Global mental health from a policy perspective: a context analysis*. London: Overseas Development Institute.
- Mackenzie, J. and Kesner, C. (2016) *Mental health funding and the SDGs: what now and who pays?* London: Overseas Development Institute.
- Patel, V., Chisholm, D., Dua, T., Laxminarayan, R. and Medina-Mora, M.E. (eds) (2015) *Mental, Neurological, and Substance Use Disorders. Disease Control Priorities*, third edition, volume 4. Washington, DC: World Bank.
- WHO (2013) *Mental health action plan 2013-2020*. Geneva: World Health Organization.
- WHO (2008) *Mental Health Gap Action Programme (mhGAP): scaling up care for mental, neurological and substance abuse disorders*. Geneva: World Health Organization.

Readers are encouraged to reproduce material for their own publications, as long as they are not being sold commercially. As copyright holder, ODI requests due acknowledgement and a copy of the publication. For online use, we ask readers to link to the original resource on the ODI website. This material has been funded by UK aid from the UK Government, however the views expressed do not necessarily reflect the UK Government's official policies, or those of ODI or our partners. © Overseas Development Institute 2016. This work is licensed under a Creative Commons Attribution-NonCommercial Licence (CC BY-NC 4.0).



Read more ODI Insights at odi.org/insights