Clin Schizophr Relat Psychoses
Volume 18:S1, 2024
Doi: 10.37421/2736-657X.2024.S1.001.

Clinical Schizophrenia & Related Psychoses

Mini Review

Open Access

Investing in Mental Health: Why Africa and South Asia Must Redo their Investment Cases

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Abstract

Background: There are irregularities in investment cases produced in Africa and South Asia. We discuss these irregularities and highlight the economic perspective that may be introduced to the current investment case to positively shift public policy.

Methods: This mini review uses World Bank and World Health Organization data. We also comprehensively searched the medical literature for published articles on mental health investment.

Results: We demonstrate that the current investment cases produce illogical outcomes that do not align with the risk-reward trade-off principle when estimating investment returns from alcohol programs. The investment cases also fail to cover the workforce deployment strategies to achieve tangible improvement in mental health outcomes. In most cases, the investment cases are biased towards mental health system funding and do not appreciate the factor that income inequality, the structure of the economy, and substance misuse influence mental health outlook aggressively. These factors may undermine the mental health system investment returns.

Conclusion: There is a need to re-design investment cases in both continents that are logical to economic principles and can be implemented with more clarity to address the growing burden of mental ill-health. The current investment cases must present compelling evidence on how much mental ill-health can be averted by reducing income inequality and substance misuse and re-engineering the economy from a net negative-brain capital economy to a net positive-brain capital economy. These factors will strengthen the policy position for investing in mental health.

Keywords: Mental health • Investment cases • Developing countries • HIV programs

Introduction

In 2017, the World Health Organization (WHO) developed a computational compartmental model for developing countries to use in designing mental health investment cases. Currently-only seven countries (Bangladesh, Kenya, Nepal, Philippines, Uganda, Uzbekistan, and Zimbabwe) have designed mental health investment cases in Africa and South Asia using the WHO compartmental model. However, scholars have argued that these investment cases are not implementable [1]. In this mini review, we present further limitations of the investment cases and suggest economic perspectives that may be introduced to strengthen the policy position of investing in mental health.

Mental health workforce in Africa and South Asia

Historically, health systems in Africa and South-Asia were not designed to address mental health conditions. Hence, both continents severely lack mental health spending [2], (Figure 1). The WHO has already called on governments and private sectors to end the legacy of underfunding and increase the necessary investments to improve mental ill-health [3]. So far, seven African and South Asian countries have responded to the call and designed investment cases for mental health using the World Health Organisation Compartmental Model [4]. However, the current investment cases do not reflect the required health workforce to capacitate the health system toward better mental health outcomes. Hence, it becomes impossible to understand the implementation phases required to achieve better mental health outcomes. Africa, for example, has one mental health worker per 100,000 people, compared with a global average of nine per 100,000 [5]. South Asia has five per 100,000 [6]. The investment cases must communicate robust workforce deployment strategies to achieve tangible mental health outcomes. Unfortunately, the seven active investment cases have not captured such a reality (Figure 1).

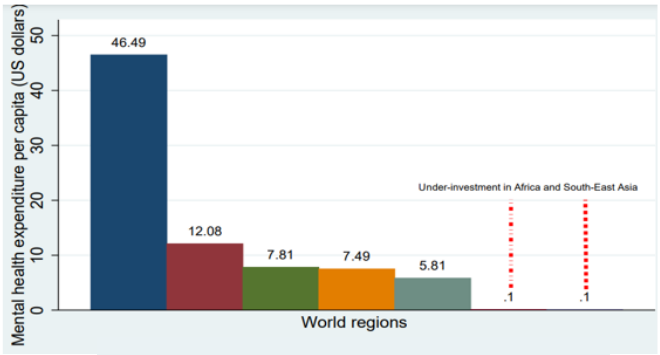

Figure 1. 2020 global spending on mental health per capita. **Note:** (■) Europe; (■) Americas; (■) Western Pacific; (■) South-East Asia; (■) Eastern Mediterranean; (■) Global; (■) Africa.

Integrating mental health services into primary healthcare

Globally, strong arguments favour integrating mental health services

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Received: 13-Feb-2024, Manuscript No. CSRP-24-127540; **Editor assigned:** 16-Feb-2024, PreQC No. CSRP-24-127540 (PQ); **Reviewed:** 01-Mar-2024, QC No. CSRP-24-127540; **Revised:** 08-Mar-2024, Manuscript No. CSRP-24-127540 (R); **Published:** 15-Mar-2024; DOI: 10.37421/2736-657X.2024.S1.001.

into primary healthcare and doing away with fragmentations [7]. Such integration is cost-effective for rendering mental health services. However, the current investment cases view mental health services as vertical stand-alone services. None of the investment cases has estimated the cost of integrating mental health services into the existing primary healthcare services [4]. Integrated services are cheaper and more viable to implement. A recent report issued by the World Health Organisation supports the integration of mental health services into the current HIV services [7]. Therefore, the notion of the current investment cases perceiving mental health services as vertical stand-alone programs is incorrect and may not serve the two continents sustainably.

Literature Review

Governance of mental health systems in Africa and South Asia

Many health systems in Africa and South Asia have no policies to boost the governance capacity [8,9], resulting in poor outcomes. Corruption, weak procurement and distribution systems adversely affect drug supply [8,9]. In some instances, there are unnecessary mark-ups along the distribution chain of drugs, and, in some countries, fee-splitting between pharmacists and physicians exists-inflating drug prices [9].

The absence of capital planning and poor Health Technology Assessment (HTA) policies would mean that mental health drugs and technologies will be purchased for their ability to generate fees rather than their appropriateness to advance mental health outcomes for the general population. Fixing these governance failures by adopting comprehensive HTA policies will significantly improve mental health outcomes without wasteful spending. The current investment cases need to acknowledge these factors.

Indeed, addressing mental health issues requires long-term relationships between patients and multi-disciplinary teams of health experts. Due to the chronic nature of these conditions, it will not be easy to manage these conditions without a reliable drug supply [10]. Donor funding-which most health systems rely on-has often shied away from funding essential drugs. For example, those working in HIV programs have learned that funding for drugs is not enough [11], a lesson already learned by those trying to ensure treatment for insulin-dependent diabetes [12].

As a result of drug shortages-many mental health systems in Africa and South-Asia cannot adequately manage complex mental health cases. There is a need for a modest 10 percent investment in mental health drugs from the current health budgets [13]. Unfortunately, the current investment cases assume optimal drug supply and do not control for donor funding shortfalls, which is endemic in these types of settings. The seven active investment cases must be sensitized to these realities to predict reasonable outcomes.

Commercial determinant factors of mental health

The failure to aggressively confront the commercial determinant factors of mental health conditions is the biggest downfall of the current investment cases. Products underlying the epidemic of chronic mental health conditions, such as cannabis, tobacco, and sugar-dense processed food, are being marketed aggressively in Africa and South-Asia and contribute the lion's share to mental ill-health [14]. Therefore, progressive programs designed to prevent or minimize these products' consumption will support the resilience of the mental health system in averting mental ill health [15]. The current investment cases have omitted this aspect.

Alcohol is the only substance abuse program featured in seven active investment cases [4]. Even in such a scenario, the investment returns from alcohol programs are completely illogical in Table 1. For example, recent World Bank estimates show that Bangladesh consumes 0.005 L of alcohol per capita [16]. The investment case states that for every dollar spent reducing this meek alcohol consumption level, the countries can achieve an investment return of US $10.0 [4], (Table 1). Uganda consumes 12.214 L of alcohol per capita [16], the investment case states that for every dollar spent in reducing the 12.214 L consumption, the country will achieve an investment return equivalent to US $0.2 [4], (Table 1).

Nepal consumes 1.363 L of alcohol per capita [16], the investment case state that for every dollar spent on reducing the 1.363 L consumption level, the country will achieve an investment return equivalent to US $6.6 [4]. The Philippines consumes 6.181 L of alcohol per capita [16], the investment case states that for every dollar spent in reducing the 6.181 L consumption level, the country will achieve an investment return equivalent to US $2.8 [4].

Based on these figures, an interesting question arises: How can countries that consume less alcohol record high investment returns as if they were aggressive drinkers? Put differently, how can a country with high alcohol consumption still record lower returns when it addresses the alcohol consumption burden? These estimates break the risk-reward trade-off principle, and one may question the validity of the presented results and the reliability of the investment cases as a whole [1].

The economy as a root cause for mental health outlook

Better mental health outcomes are likely influenced by development policies and programs designed to advance economic growth, education outcomes, health promotion, eradication of poverty, hunger, income inequalities, substance misuse, and other commercial determinants factors such as gambling. Individuals in a position of privilege and good development have options not to consume drugs and substances as a means of escaping the grinding realities of life challenges. Such individuals do not rely on gambling for economic survival.

On the other hand, disadvantaged individuals have no option but to indulge cheaply in gambling, drugs, and substances because of a lack of dignity and chronic economic marginalization. Such reality is a recipe for mental ill-health in Africa and South-Asia, which needs to be averted by a comprehensive social security system and a growing net positive brain capital economy (a strong economy built on a cohesive society that is resilient to mental ill-health) [17].

Indeed, investing directly in the mental health system is essential for Africa and South Asia. However, such investment will likely be insufficient to buy resilient mental health outcomes. For example, even in high-income countries where investments in and access to mental health care have increased, the prevalence of mental ill-health remains unchanged [18]. A recent study indicates that the unchanged prevalence of mental disorders is likely due to treatment provisions that are insufficient to offset the increase in the incidence of high psychological distress driven by the economic and social environments stressors which we live in [19].

Table 1. Productivity gains from mental health investment.

	Bangladesh	Uganda	Uzbekistan	Kenya	Nepal	Philippines	Zimbabwe
Productivity gain from $1 USD investment in alcohol programs							
Investment return in $USD (reward)	10.6	0.2	0.7	2.3	6.6	2.5	0.9
Alcohol consumption per-capita (risk)	0.005	12.214	2.602	2.865	1.363	6.181	3.628
% Share of adults who drink (risk)	2.2	36.3	20.8	23.9	27.1	33.1	17.6

Note: Authors Analysis. Mental health productivity gains are derived from the investment case report [4]. Alcohol consumption per-capita came from the World Bank [16]. Share of adults who drink came from World Health Organization (WHO).

Global literature shows that various economic and social environmental stressors influence mental health outcomes. Such factors include adverse early life exposures, substance misuse, exposure to family and community violence, unemployment, financial insecurity, poverty, poor education, homelessness, inequality, racism, social exclusion, natural disasters, and climate change. These factors have both unidirectional and bidirectional relationships with mental health in a complex causal web [20]. Therefore, structural equation modelling is needed in Africa and South Asia to tease out the most relevant factors that drive mental ill-health in these regions. The investment cases should be designed after the outcomes of such structural equation modelling to ensure that the limited resources are deployed strategically instead of assuming that the public clinic services will be the most cost-effective strategy to avert mental ill-health.

Discussion

Currently, the World Health Organization's comprehensive Mental Health Action Plan 2013-2030 calls for partnerships across health, education, employment, housing, private, and judicial sectors to deliver a comprehensive and coordinated response to avert mental ill-health [21]. Such a call is welcomed as a starting point to reimagine the ways of investing to address mental ill-health. However, we must honestly ask the question: To what extent are we missing an opportunity to understand and address the root causes of mental ill-health in the modern-day economy? To us undoubtedly, economic decline, income inequality, substance abuse worsens mental health outcomes [22], and investment cases need to be situated on that economic perspective.

For example, the investment cases should provide clear answers to questions such as: What would happen to the mental health outlook of Africans and South Asians if income inequality and substance abuse were not addressed under the current economic environment? Unfortunately, this macroeconomic perspective is lacking in the seven investment cases, robbing us of critical answers to shift public health policy.

Rising income inequality and substance misuse in a net negative-brain capital economy weaken the individual agency, create resentment, erode social capital, trust, and increase crime rates [23]. These economic factors also contribute to political polarization, social unrest, and erosion of community cohesion as societies get easily polarize on issues such as wealth redistribution. Rising income inequality and substance misuse in a net negative-brain capital economy also undermine growth by erasing productive potential throughout life course and across generations.

Recent systematic reviews confirm an association between income inequality and poorer mental health, including a greater risk of depression in populations with higher income inequality relative to populations with lower inequality and greater impacts among women and low-income groups [24]. This evidence is of significant concern given that inequality within African and Asian nations is growing. Therefore, the current investment cases need to present compelling evidence on how much mental ill-health can be averted by reducing income inequality and substance misuse and re-engineering the economy from a net negative-brain capital economy to a net positive-brain capital economy [25].

Conclusion

It is not aggressive investment into hospi-centric commodities that will drive sustainable improvement in mental health outcomes in Africa and Asian countries as communicated by the investment cases, but whether we have addressed the fundal core drivers of mental ill-health outside the mental health systems. Global evidence shows that growth in income per capita and high health spending may not buy high health outcomes due to widening income inequalities. Other authors argue that income inequality is independently associated with higher health spending due to the worsening health of the poor population.

Therefore-although the mental healthcare system has the potential to improve health outcomes, especially among the ill and economically disadvantaged, the returns of high health spending in mental health system are disappointingly small and become insignificant in the long run. The link between the economy, income inequality and mental health outcomes requires due attention, primarily where national prosperity benefits a small share of the population and where the gap between haves and have-nots is widening ever further. This inequality appears to blunt improvements in health outcomes despite high health spending.

Redistributing the income better, addressing substance misuse, and lean investment in mental health systems is likely to offer the last solution for the mental health burden of Africa and Asia. Unfortunately, the current investment cases have not embraced these factors comprehensively, which renders them less competent in addressing the epidemiology of mental ill-health strategically. There is a need to re-design investment cases in both continents that are logical to economic principles and can be implemented with more clarity to address the growing burden of mental ill-health.

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How to cite this article: Mostert Cyprian M, Chi Udeh-Momoh, Olivera Nesic, et al. "Investing in Mental Health: Why Africa and South Asia Must Redo their Investment Cases". *Clin Schizophr Relat Psychoses* 18:S1 (2024). Doi: 10.37421/2736-657X.2024.S1.001.