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COMMENTARY TO SPECIAL ARTICLE

Making Universal Health Coverage a reality: bridging the gap between Global Mental Health and practical integration into local health systems

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Commentary on: Scaling-up services for psychosis, depression and epilepsy in sub-Saharan Africa and South Asia: development and application of a mental health systems planning tool (OneHealth). doi: 10.1017/S204579601600408

The field of Global Mental Health (GMH) has made substantial progress in generating an evidence base, gaining increased resource allocation and having an impact on global policy frameworks. The work described in this issue by Chisholm *et al*. (2017, this issue) sets out to address some of the practical challenges in translating these successes into meaningful impact at a local level.

The Emerald project aims to strengthen emerging health services by enhancing health system performance (Semrau *et al*. 2015). The development and testing of an adapted version of the World Health Organisation (WHO) OneHealth tool, described in the article, is a key contribution to supporting pragmatic decision-making in national and district-level service strengthening. The tool seeks to provide clear information on resources necessary to provide different packages of health care, enabling planning and balancing priorities between conditions. This version specifically focuses on services for mental, neurological and substance use disorders (MNS) in low income settings. In addition, the tool is able to provide estimates of expected health impacts, which begins to fill an essential gap in addressing the challenge that advocates for greater equity in mental health care globally have faced in justifying investment in this historically under-resourced area.

The term 'Global Mental Health' first gained prominence with the publication of a *Lancet* series on this topic (Lancet Global Mental Health, 2007), and defined a discipline that gradually articulated a common approach to application of an increasingly compelling evidence-base to improved health and equity in what had previously been a disparate and fractured body of knowledge (Patel & Prince, 2010). The initial focus of the GMH agenda has been to generate evidence for scaling up innovative services in order to narrow the treatment gap in mental health, and to address the human rights abuse experienced by people with mental conditions. This focus helped to drive an international research agenda (Collins *et al*. 2011), though more concrete progress has been achieved in the first of these priorities.

Mental health is increasingly being recognised as an important component in global development, though the pace of implementation is lagging behind that of research. Translational research has laid an important foundation for policy and practice, producing evidence-based normative materials for treatment interventions (Barbui *et al*. 2010). Mental health systems have long resisted reform in low income settings, and remain chronically under-resourced (WHO, 2014). There is now strong evidence that, improved outcomes can be achieved through processes of health systems reform that decentralise services, for example through integration into secondary and primary health care, and engagement of non-specialist workers such as health and social workers through task-sharing (van Ginneken *et al*. 2011).

Importantly, the wider community of implementers, policy-makers and service user advocates have been engaged in shaping the research agenda. For example, following initial criticism of the WHO's Mental Health Gap Action Programme (mhGAP), a number of psychological and social interventions have been developed and trialled, to respond more directly to demands for pragmatic, low-cost and trans-diagnostic approaches (WHO, 2016; WHO and Columbia

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University, 2016). In future, there is likely to be a greater emphasis on user-centred, recovery-oriented models (Pelletier *et al*. 2013), informal or peer-delivered care and promotion of well-being as part of global human development, as opposed to being confined to traditional biomedical models focused on identification and treatment of disease.

One crude but informative method to measure how much attention mental health is receiving within global development is to track changes in development assistance allocated to mental health. A number of recent reviews found a three-fold increase in development assistance for Mental Health from 2007 to 2013 (Gilbert *et al*. 2015; Mackenzie & Kesner, 2016). However, the total allocation has never exceeded 1% of total development assistance for health, despite the fact that MNS disorders contribute to at least 7.4% of the total Global Burden of Disease (Whiteford *et al*. 2013), a figure that is likely to be a significant underestimate (Vigo *et al*. 2016), and that is expected to increase substantially in coming years. There is still a long way to go in order to achieve parity of investment between mental and physical health.

A number of key reports have raised the profile of mental health on the international health agenda (Patel *et al*. 2013), and a meeting hosted by the WHO and the World Bank, which brought together key institutions in global development highlighted the economic case for increased investment in mental health (Chisholm *et al*. 2016). The WHO's Comprehensive Mental Health Action Plan for 2013–2020 provides a clear framework to guide governments in mental health (WHO, 2013), and there is evidence of it starting to filter to regional and national policy (Alwan & Saeed, 2015). Mental health is now included in the Sustainable Development Goals that define development priorities through to the year 2030. By making available interventions that, when delivered at scale, can help to achieve these goals, it will be possible to demonstrate that mental health care can be delivered in a way that contributes to achievement of Universal Health Coverage (Votruba *et al*. 2014).

While calls for equity in resource allocation, clear advocacy and generation of good evidence may be effectively influencing political attitudes and actions around mental health prioritisation globally, these calls must be met with the practical means to change systems at a national level and achieve impact on access to care, coverage and quality of life of people affected by MNS conditions. To date, appropriate resources to support decision-makers in translating global momentum, or even national policy, into local practice have been limited, and simple, accessible tools for planning and implementation are needed.

Financial planning is one of the essential building blocks of health system strengthening, but appropriate tools for estimation of resource needs for mental health services are lacking. In addition to the low level of resources available for mental health, they have historically been inequitably distributed, and inefficiently used (Saxena *et al*. 2007). Support for better financial decision-making is therefore one piece of the jigsaw that needs to be completed, if local health officials are to plan for effective mental health service delivery. The existing generic OneHealth tool is software developed by the Inter-Agency Working Group on Costing established in 2008 (WHO, UNICEF, World Bank, UNAIDS, UNFPA, UNDP), which takes a systems approach, considering the human resources, medications and other necessary resources. Importantly, once context-specific data are entered into the software, the results are sensitive to local needs, costs and expected health outcomes. The capacity to apply this tool to mental health is a major advance on what has previously been available to guide local decisions in planning processes.

The addition of a mental health module to OneHealth tool by the Emerald team allows planners to take an integrated approach to mental health care. This can reduce the historical tendency towards vertical programming, and the stigmatising view that mental health services are fundamentally different in some way. The adaptation, testing and validation of the tool in six low income countries in Africa and Asia demonstrates its applicability in a number of different socioeconomic contexts with varying health resources, packages of care and targets for coverage.

The availability of detailed and locally valid data will provide confidence in planning, and important justification for greater parity in financial allocation for mental health at a local level. This allows for proper implementation of global frameworks, and learning from experiences in low- and middle-income countries. The robust process carried out to ensure generalisability of this tool for broader application should also lend itself to its use in resource-constrained areas more globally (so-called south-north learning).

Perhaps even more importantly, the capacity for the GMH community to support informed and comprehensive integration of mental health care bridges the challenging gap between theory and practice, and is an important step in mental health being considered equally in progress towards Universal Health Coverage.

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