Mental Health as a Pathway to Health Equity

Pratima Murthy, Krishna Prasad Muliyala, and Channaveerachari Naveen Kumar

Equity, diversity, and inclusiveness are the basic tenets of distributive justice and are essential goals for development. The World Health Organization (WHO) envisages that health equity can be achieved when everyone attains their full potential for health and well-being. This includes mental health. According to WHO's definition, 'mental health' is a state of mental well-being that enables people to cope with the stresses of life, realise their abilities, learn well and work well, and contribute to their community.[1]

Mental health is closely linked with many of the United Nations (UN) Sustainable Development Goals (SDGs).[2] It comprises people's individual and collective abilities to make decisions, build relationships, and shape the world, and is more than the mere absence of mental illness. In its broadest sense, mental health encompasses promotive and preventive aspects, while mental disorders or illnesses (used interchangeably in this article) are more focused on treatment and rehabilitative aspects. However, mental health and well-being is equally important for persons with mental disorders, as much as it is for those without such disorders.

Integrating Mental Health into General Healthcare

The complex interaction of biological, psychological, and social determinants shapes an individual's mental health. There is evidence that poverty and other adverse social circumstances are risk factors for poor mental health, and for mental disorders. Biological vulnerability as well as psychosocial distress predispose an individual to common mental disorders like depression, substance use disorders, and behavioural addictions.[3] They can also be reasons for relapse for episodes of severe mental illness (SMI) such as schizophrenia or bipolar mood disorder.

The relationship between social adversity, mental distress, mental and physical illness is both interactive and complex. The presence of mental illness, particularly SMI, can drive people to poverty and worsen mental distress for both the individual and their family. Similarly, psychosocial adversity is a recognised risk factor in conditions like diabetes and tuberculosis and influences health outcomes.[4,5] Socioeconomic, political, cultural and place-based conditions all determine health outcomes, including on mental health.

Multimorbidity—defined as the co-occurrence of more than one chronic condition in an individual—can occur a decade earlier in those who are experiencing socioeconomic vulnerabilities.[6] When two or more conditions cluster together (both contributing and resulting in socioeconomic inequalities), medical specialists use the term 'syndemic' to describe such a situation. Therefore, the contextual determinants of health and disease are paramount in the conceptual framework of syndemics. Moreover, the two or more chronic conditions can interact and lead to adverse mutual outcomes for the conditions. The imperative, therefore, is to shed a dichotomous approach to mental and physical health and integrate them both in healthcare service delivery.

The challenge is how to efficiently distribute healthcare resources to those who most need them. In many regions of the world, while disadvantaged populations need greater healthcare, they receive less.[7] Some sections of society (for example, those with mental illness) may warrant greater allocations of resources, as much as equal treatment is required for similar needs. Health economists and the World Health Organization (WHO) have

argued that investing in mental health is important from the point of view of improving population health and reducing social inequality, promoting human rights, and improving economic efficiency.[8] The economic implications of mental and substance disorders can be enormous: for example, the global economic loss due to common mental disorders is an estimated US$ 1 trillion per year.[9] Given the increasing prevalence of mental illness, the costs are likely to only further mount. Investment in treatment of mental illness can result in large economic productivity gains.[10]

The Burden of Mental Health, Substance Use Disorders and Multimorbidity

Mental and substance-abuse disorders are leading contributors to premature morbidity and mortality globally. In India, for example, the National Mental Health Survey (NMHS), 2015-16, has reported a 13.6-percent lifetime prevalence of any mental/substance-abuse disorder morbidity.[11] The overall number of Disability-Adjusted-Life-Years (DALYs) for mental disorders has increased by more than 50 percent between 1990 and 2019.[12] This growth pattern is expected to continue, necessitating a proportionate response from the health systems. Most of the mental and substance abuse disorders are chronic and disabling conditions. The treatment gap for mental and substance abuse disorders (defined as proportions of those needing care but not receiving) remains high (about 75 percent), contributing to the high burden at various levels (individual, family and community). A vast majority of the population cannot afford out-of-pocket (OOP) spending for the treatment of mental and substance abuse disorders and psychiatric rehabilitation.

Such out-of-pocket expenditure, in India, is dominated by medicines.[13] In more than half of the population, non-medical costs such as expenses on travel and accommodation contribute to more than one-third of OOP spending. The share of doctors' fees and diagnostic charges in OOP expenditure is high in private healthcare settings.[14] Discrimination in the coverage by health insurance toward mental illness significantly raises the chances of catastrophic spending in such circumstances. Despite the Insurance Regulatory and Development Authority of India (IRDAI) having directed Indian insurance companies to cover mental illnesses as per the

Mental Health Care Act, 2017, there have been many reported violations of the provision of the Act.[15] The violations have included rejections of claims for mental illness by insurance companies and discriminatory ceilings on the sum of reimbursement for mental illness.

Worldwide, people with SMI have shortened life expectancy by 10-20 years, which is explained by the high rates of multimorbidity.[16] Yet the interventions to address the multimorbidity, primarily non-communicable diseases (NCDs) and the associated risk factors such as tobacco and alcohol use, physical inactivity, and poor diets—are insufficient for this group. The existing national programs to address these chronic conditions seem oriented vertically with poor horizontal integration across the programmes. Homeless persons, women, persons with developmental disorders, and elderly with mental illness experience even further inequities among the unequal.

The living conditions of persons in India with SMI chronically and who reside in psychiatric hospitals have been highlighted through public interest litigations and addressed by the active intervention of the judiciary. The National Human Rights Commission (NHRC), with the technical support of the National Institute of Mental Health & Neuro Sciences (NIMHANS), Bengaluru, has reviewed the rights violations of persons with SMI in these hospitals and monitored the required systemic changes.[17,18]

Over the last two decades, there have been consistent efforts toward developing a better systemic response in the care of persons with mental illness.

Key Efforts in Improving Mental Healthcare in India

The NMHS, 2015-16, India, reported the current prevalence of any mental morbidity to be 10.56 percent.[19] Those with low education and lower income, and are middle-aged were at the highest risk for mental illness.[20] Only two out of every 10 individuals with mental illness received mental healthcare.[21] Lack of mental health resources (e.g., shortage of mental health professionals), poor mental health literacy, stigma and discrimination,

social inequality, gender issues and lack of community participation may be among the various factors that impede mental health equity in India.

To be sure, India has made strides toward improving mental healthcare (summarised in Box 1). India was one of the first Asian countries to have a National Program for Mental Health (NMHP; as early as 1982). The District Mental Health Program (DMHP) today covers 700 districts across the country. The DMHP is the implementation arm of the NMHP tasked to ensure the availability and accessibility of minimum mental healthcare, integration of mental health in general healthcare, and to promote community participation in mental health development.

Box 1. Initiatives in India to Ensure Equitable Mental Healthcare

Programmes:

- Expansion of the National Mental Health Programme – District Mental Health Programme (>700 districts) and Taluk Mental Health programme (e.g., Karnataka)
- Ayushman Bharat-Pradhan Mantri Jan Arogya Yojna (PM-JAY) – Universal Health Coverage, Health and Wellness Centres
- National Tele Mental Health Programme (Tele Mental Health Assistance and Networking Across States: Tele-MANAS)
- Generic medicines – Jan Aushadhi Kendras

Policies:

- National Mental Health Policy (2014)
- National Health Policy (2017)

Legislations:

- Rights of Persons with Disability Act, 2016
- Mental Health Care Act, 2017

Moreover, the availability of psychotropic medications in primary healthcare has also improved. Screening and basic management of mental illness have been incorporated into the services offered at Health and Wellness Centres (HWC). India has a progressive Mental Health Policy (2014) based on equity, justice, integrated and evidence-based care in a rights-based approach.[22]

The use of digital technology is being leveraged for training and expanding human resources for mental health care in the country through digital academies at NIMHANS as well as other institutions. The National Tobacco Control Program has employed a mobile-based strategy called m-Cessation and tobacco quit-lines to support those who wish to quit tobacco.[23,24] The Government of India launched the National Tele Mental Health Program (Tele Mental Health Assistance and Networking Across States: Tele-MANAS) initiative on World Mental Health Day, 2022, to provide 24/7 comprehensive tele-mental health services that cater to remote and underserved areas.[25] The Tele-MANAS initiative—a phone-based, counsellor-led service—aims to address mental distress, identify mental illnesses and behaviours that need specialist mental health referrals, and improve service networking in each State/Union Territory. The examples of digital technology-based initiatives in India for mental health are summarised in Box 2.

Box 2. Technological Initiatives in India for Mental Health

- **Telephone/mobile based:** Quitline, m-cessation (tobacco), *Nikshay Sampark* (TB helpline), Tele-MANAS (National Tele-mental health programme), *Kiran* (mental health rehabilitation), COVID-19 psychosocial helpline, suicide helplines, crisis helplines for elderly, women, children, farmers
- **E-healthcare:** eSanjeevani (National Telemedicine Service of India), e-Manas Karnataka (Mental Healthcare Management System)
- **Training:** NIMHANS digital academy, Telemedicine Centre, NIMHANS, CIP Digital Academy, LGBRIMH Digital Academy
- **Telepsychiatry:** NIMHANS ECHO model, PGIMER "Tele-enabling model"
- **Potential uses:** chatbots, telerehabilitation, self-help

The Government of India's flagship insurance scheme, Ayushman Bharat-Pradhan Mantri Jan Arogya Yojna (PM-JAY), aims to achieve Universal Health Care (UHC) in India.[26] The scheme will cover most secondary and tertiary hospitalisations for nearly 40 percent of the population. The annual coverage of INR 500,000 per family is irrespective of family size. The scheme does not, however, cover outpatient expenses. Generic medicines have been made available in Jan Aushadhi Kendras.[27] The availability of generic medicines at cheaper rates than branded drugs will likely reduce the economic burden for all sections of society, especially the poor and marginalised. The second pillar of the PM-JAY is the provision of universal, comprehensive healthcare in primary care through the 150,000 Health and Wellness Centres (HWC). The HWC will act as the first point of contact for comprehensive services, including screening and essential mental health conditions management.

Two progressive legislations were enacted by the Government of India in the backdrop of the United Nations Convention on the Rights of Persons with Disability to address critical concerns of inequality and inequity in mental healthcare. The Rights of Persons with Disability Act (RPWD), 2016 has provided a reservation of 1 percent for mental illness-related disabilities in recruitment to government jobs or aided organisations.[28] The Act guarantees reasonable accommodation in education and work in government institutions for persons with disability. The Mental Health Care Act (MHCA) 2017 provides the right to access mental healthcare and treatment from mental health services run or funded by the appropriate Government.[29] The provision under the Act encompasses a range of services for persons with mental illness, including psychiatric rehabilitation and community reintegration. The Act also underscores the need for integrating mental health services with general health services at all levels. The MHCA 2017 also directs parity for mental illness in health insurance as is available for physical conditions. Appointing persons with mental illness, their family members and NGOs in the Central and State Mental Health Authorities and the Mental Health Review Boards is an affirmative step towards ensuring checks and balances in the delivery of mental healthcare in an equitable manner.

Thus, there have been improvements in curative and preventive care domains for mental and substance use disorders in the last decade. However, these need to be translated on the ground. There is also still a lack of adequate focus on rehabilitative care, which remains restricted to select tertiary care mental health institutions.

The Way Forward

If the vision of the National Mental Health Policy 2014 must be truly realised, its strategic directions and recommendations for action will need to be implemented. The distinct mental health needs of vulnerable populations such as children, the elderly, the homeless, require to be addressed. Macro-environmental issues such as poverty, unemployment, displacement, and emerging concerns such as the mental health impact of climate change require particular focus. Leadership and governance at various levels must be strengthened. Mental health systems should be strengthened at various levels to provide decentralised care in smaller administrative units such as the *taluks*/blocks.

Preventive and promotive aspects of mental health provide an opportunity to integrate existing mainstream/biomedical as well as alternative/traditional systems of care, including Yoga. Mental health should be effectively addressed at the workplace. The mental health of children and adolescents should take primacy and can be addressed in educational settings.

However, given that there may be a substantial group of out-of-school children and adolescents, as well as a large proportion of the population that works in the unorganised sector, there is a need to expand the reach of access to mental healthcare. A life-span approach to mental healthcare, extending from perinatal care to elderly care is recommended. Research in public mental health aspects is another priority. Mental health indicators need to be standardised and incorporated in governance regularly. The comprehensive set of interrelated services has been deemed necessary in the *World Mental Health Report, 2022* –these cover the life cycle, from maternal and child mental health, to the elderly.[30]

Inequity in mental healthcare needs to be systematically measured and monitored in LMICs to identify gaps and to inform policies and programmes. WHO has developed the Health Equity Assessment Toolkit (HEAT and HEAT Plus) software to explore and compare within-country health inequalities and across settings using disaggregated datasets.[31] Simultaneously, there is a need to learn from successful models developed in High-Income Countries (HICs). For example, in the United Kingdom (UK), the National Health Service (NHS) through the Five-Year Forward View for Mental Health has prioritised addressing inequity.[32] There have been debates in the public health domain for "disparity interventions" that are specifically designed for populations that face inequality.[33] Most of the existing inequality interventions in the mental health field from the HICs have focused on racial disparities, age-related factors, and socioeconomic issues. While developing, testing, and implementing the interventions, at each stage, all stakeholders including the service users will have to get involved.

To ensure universal health coverage for mental health, specific efforts have been conducted by WHO in six early adopter countries. Inadequate human resource and inequitable distribution of specialists were reported to be the crucial issues in the situational analysis.[34] In India, for the PM-JAY to meet the goal of universal health coverage, service delivery needs to be strengthened at all levels and systems to maintain continuity of care must be created, an area that is particularly relevant for mental health.[35] The coverage for non-PM-JAY patients, specifically non-below poverty line but belonging to lower/middle socioeconomic classes will have to be addressed to reduce catastrophic spending.[36] Mechanisms of surveillance and health information must be further strengthened to encompass private healthcare providers.

The national programmes for non-communicable diseases and chronic communicable diseases such as Tuberculosis need to consider that most patients with these conditions have multimorbidity and align the programmes with the NMHP at various levels. Integration of care at the primary care level and the HWC will have to be implemented as envisioned in the PM-JAY, with an emphasis to improve patient reported outcomes, besides clinical outcomes. There is sufficient evidence for self-management and peer-based interventions for chronic conditions that have emerged and have been successfully implemented in HICs.[37,38] They must be adapted

to the cultural settings of LMICs. The effectiveness of brief psychological interventions delivered by lay counsellors for moderate to severe depressive disorders and harmful drinking in primary care has been demonstrated in India.[39,40]

These low-cost interventions may have important lessons for HIC as the health systems in HICs are overwhelmed with long waiting periods for psychological intervention. Low-intensity interventions such as WHO's Problem Management plus (PM+) can be used in low-human resource settings for adults in distress due to exposure to adversity.[41] Families are an important resource for care provision in LMICs, specifically in the context of mental health and the role and concerns of family caregivers must be formally addressed. Indigenous interventions such as Yoga as well as alternative forms of medicine have potential benefits for multimorbidity. An evidence-based integration into the public health system may enhance outcomes as they are culturally acceptable and may have a broad spectrum of action.

Technology has been harnessed in healthcare in India as exemplified by the Tele-MANAS programme. However, the metrics to monitor the implementation of the programme should encompass inequities in the delivery of virtual care. Methods to enhance digital literacy and adaptation of the care so that even those with low digital literacy can comfortably use the portals of care, need to be considered during implementation. As primary healthcare is the locus of UHC, addressing the referral pathways with monitoring of the referrals, robust information systems and integration of mental and physical care are central to improving outcomes. The successful translation of policies and programmes on the ground requires governmental engagement as well as that of all stakeholders to ensure equitable and quality healthcare.

Dr. Pratima Murthy, *Director and Senior Professor of Psychiatry, NIMHANS, Bengaluru*

Dr. Krishna Prasad Muliyala, *Additional Professor of Psychiatry, NIMHANS, Bengaluru*

Dr. Channaveerachari Naveen Kumar, *Professor of Psychiatry and Head of Community Psychiatry, NIMHANS, Bengaluru*