Towards universal health coverage for people living with mental illness in South Africa

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Given its human rights-based Constitution of 1996 and as signatory to the United Nations Convention on the Rights of Persons with Disabilities, South Africa is obliged to provide equitable access to care for those with serious mental illness (SMI). Universal health coverage (UHC) means that all people are able to access the health care they need without incurring financial hardship. With the release of the National Health Insurance White Paper in 2017, South Africa confirmed the process of transforming its healthcare system to ensure UHC, including for people living with mental illness (PLWMI).

However, with multiple competing health priorities, there is a risk that mental health may not be addressed, particularly for those with serious mental illness (SMI). The severe functional impairment and psychosocial disability related to SMI limits the individual’s ability to access health care, unless specifically catered for by the health system. At present, both the public and private health sectors are characterised by poorly resourced, fragmented, mainly hospital-based mental health care. Notably, if National Health Insurance does not provide financial protection, it is likely to perpetuate inequity and neglect in the health and mental health care of PLWMI.

This chapter explores UHC for PLWMI in South Africa, with consideration given to the burden of disease due to SMI, current mental health services, and national health policy and plans. We conclude with key recommendations to accelerate progress towards UHC for PLWMI, including the need for a paradigm shift in the organisation and funding of mental health services.

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Introduction

South Africa is committed to achieving universal health coverage (UHC) and has embarked on the implementation of a national health insurance system to attain this goal.1 According to the World Health Organization (WHO), UHC “means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.”2 UHC embraces the Sustainable Development Goals, which include mental health in parity with general health, in the Declaration and in health targets 3.4 and 3.8.3

Thus, UHC should ensure that people living with mental illness (PLWMI) enjoy equitable access to effective mental and general health care, with adequate financial protection. For health financing to be sustainable, the WHO recommends targeted budgeting, appropriate to the health priorities of the country, with cost-effective health systems and efficient utilisation of resources.2 As stated by Mayosi et al.,4 “the challenge [in South Africa] remains to scale up appropriate mental health services for the benefit of the whole population.” Importantly, this challenge is against the backdrop of South Africa’s quadruple disease burden, each competing for its portion of the health budget.

The term ‘mental illness’ adds to the complexity of priority setting in UHC. It encompasses a broad range of conditions, whether mild, moderate or severe.5 Such a wide range of illness raises the pragmatic and ethical question of whether to allocate resources to the larger population with common mental illness, such as depression and anxiety, or to those with less prevalent but more severe conditions, such as schizophrenia and bipolar disorder.5,6 An ideal mental health system should meet the needs of all in an affordable manner.7 However, the marked functional impairment and disturbed behaviour rendered by severe conditions may predispose this subpopulation to neglect, if not outright discrimination, within the health system.

The term ‘serious mental illness’ (SMI) is used for health-planning purposes. SMI cuts across diagnostic categories to include any mental, behavioural or emotional disorder in a person over 18 years that causes marked functional impairment. It includes conditions such as severe anxiety, eating disorders and personality disorders, as well as psychotic and mood disorders.5,7 Unless comorbid with another psychiatric disorder, it excludes dementias, mental disorders due to another medical condition, developmental disorders, and substance use disorders. SMI carries a significantly higher risk of all-cause mortality compared with the general population.8

Because of the impact of disability and the risk of neglect in health services, this chapter explores UHC for adults with SMI in the context of South African mental health services and policy development. The acronym PLWMI used in the chapter therefore refers to this patient population.

Burden of disease due to serious mental illness in South Africa

The 2015 Global Burden of Disease Study ranked depression as the 4th and anxiety the 10th leading cause of disease burden due to years lived with disability in South Africa.9 Using the 12-month prevalence rate of 3.3% for severe depression and anxiety found by the South African Stress and Health Study, Lund et al.10 estimated the annual cost of these two conditions in lost income at US$4 798 per person. This equated to over US$3.6 billion for the country when extrapolated to the population aged 20–64 years in 2001. There are no nationally representative epidemiological studies of other SMI such as schizophrenia or bipolar disorder. Analysing the 2010 Global Burden of Disease study, Baxter et al.6 found that in Southern Africa, prevalence data for schizophrenia covered less than 0.1% of the general population and there were no prevalence data for bipolar disorder.

Hence, while the burden of disease due to severe depression and anxiety is well recognised, the burden due to other SMI is unknown. Although international prevalence estimates may be used, these do not reflect the bi-directional relationship between SMI and the significant societal stressors in South Africa, or between SMI and other causes of high disease burden, such as HIV infection, interpersonal violence, and road injuries.11

Psychosocial disability and universal health coverage

Consistent with its human rights-based Constitution (Act 108 of 1996),12 South Africa is signatory to the United Nations Convention on the Rights of Persons with Disabilities,11 and therefore committed to ensuring the “full and equal enjoyment of all human rights and fundamental freedoms” for people with disabilities in equity with others. The Convention considers people with mental impairment in parity with those with physical, intellectual or sensory impairments. Disability refers to the hindrance to full and effective participation in society resulting from the interaction between the impairment and the person’s social and physical environment. Psychosocial disability refers to the stigma, discrimination and inability to participate in society experienced by PLWMI due to the interaction between mental impairment and the environment.13

As PLWMI experience an inability to access or utilise health, education and employment opportunities, psychosocial disability entrenches the poverty cycle and perpetuates ill-health. Ensuring the right to health care of PLWMI is further complicated by impaired insight, judgement and cognitive function caused by SMI.14 Decision-making and help-seeking are often negatively affected and may inadvertently result in denial of treatment for acute illness episodes and of preventive, rehabilitative or palliative care for enduring conditions.

The Convention on the Rights of Persons with Disabilities has far-reaching implications for UHC of PLWMI in South Africa. Equitable access implies that enough additional support is provided by the health system, other government sectors, and civil society to ensure that the right to healthcare services is observed. Quality care must be effective not only in relieving acute symptoms, but also in preventing relapse, impairment, and subsequent disability. Financial protection is needed to prevent further worsening of the poverty cycle associated with SMI.

In short, a transformation of South African society, social services, and the health system is required to facilitate full participation of PLWMI.11 The National Mental Health Policy Framework and Strategic Plan 2013–2020 (NMHPF)15 outlines an action plan in which mental health care is delivered in a variety of settings and at different service levels. For PLWMI, community-based mental health
services, general hospital psychiatric units, and psychiatric hospitals are necessary, along with primary health care (PHC) and services from the non-health and non-governmental sectors. The objectives of the NMHPF are consistent with the global objectives monitored by the WHO Mental Health Atlas.16

Mental health services in South Africa

South Africa has a two-tier health system, with the total health expenditure split equally between the public and private health sectors.1 Eighty-four per cent of the population receive care in the public health sector, funded mainly from the national fiscus. The other 16% purchase health care from private providers, using pre-paid health insurance intermediaries (medical schemes) and/or out-of-pocket cash payments. Although both sectors are subject to the same national mental health legislation and policy, the population groups served differ considerably.

Public health sector

As the public health sector caters for those unable to access private health funding, it carries the burden of care for PLWMI with severe psychosocial disability. However, it is characterised by a shortage of mental health professionals. The WHO Mental Health Atlas South African profile (2014),16 documents 0.4 public-sector psychiatrists/100 000 population, but has no figures for other members of the mental health workforce, including medical doctors, psychologists, nurses, occupational therapists, or social workers. In the case of nurses, the situation is dire, with a projected severe shortage related to changes in nursing education and curriculum.17

The public sector mental health system has followed a deinstitutionalisation process since the mid-1990s,15,18 consistent with global trends in mental health care, the Constitution,12 and the Mental Health Care Act (17 of 2002).19 Section 8 of the Mental Health Care Act stipulates that mental health services be provided in a manner that facilitates community care. To implement this, the National Department of Health (NDoH) published human resource norms for severe psychiatric conditions.20 The norms reflect the ‘balanced care model’23 and specify specialist-level multidisciplinary staffing of community-based mental health services and the development of general hospital psychiatric units. Targets of 10 beds/100 000 population for psychiatric institutions and 28 beds/100 000 population for general hospital psychiatric wards were set, together with figures for community-based residential beds and day care facilities. However, implementation of the Mental Health Care Act was not funded, and mental health financing remained institution-based. This resulted in a haphazard process of deinstitutionalisation with erratic or no development of community mental health services, and, in some areas, re-institutionalisation.11,21-24

A WHO survey21 using 2005 data found general hospital and community residential psychiatric beds in South Africa to be only 10% of the recommended norms, despite a 7.7% reduction in the number of institution beds over the preceding five years to 18/100 000 population. In 2014, South Africa reported 22.7 institution beds/100 000 population to the WHO Mental Health Atlas,16 but provided no data on general hospital or community residential beds. A continued reliance on institution beds is also reflected in the 2014/15 District Health Barometer,25 which revealed psychiatric admission rates to be higher in districts with specialised psychiatric hospitals. Most disturbing though is the

insidious, inhumane, re-institutionalisation of PLWMI evident in South African prisons26 and forensic psychiatry units.27

In Gauteng, the number of long-stay hospital beds was halved from 70 to 35 beds/100 000 population between 1994 and 2004.18 Further deinstitutionalisation towards the goal of 10 beds/100 000 population continued until 2008, when repeated readmissions prevented further bed reductions.18 However, the corresponding development of community-based mental health services and community residential beds was not sustained,22 and their gross inadequacy was made painfully obvious in the Gauteng Mental Health Marathon Project (GMHMP) in 2015/16 (Box 1). In this project, the last institution beds in the province were rapidly closed, leading to an excessive loss of life.

Box 1: The Tragedy of the Gauteng Mental Health Marathon Project

In a bid to save costs, and justified by the deinstitutionalisation process, 1 442 people with severe psychosocial and other disabilities were transferred out of long-stay medium-care hospitals between October 2015 and June 2016 to either specialised psychiatric hospitals, which were renovated and staffed for the purpose, a government-run care and rehabilitation centre, or non-governmental residential facilities (NGOs).28 119 patients (8.3%) died within a year of transfer, and 131 (9.1%) died during the 2016 calendar year.28 The age-adjusted death rate for 2016 was 63/1 000 people, and the overall standardised mortality ratio was 4.9.

Those transferred to a specialised psychiatric hospital were significantly more likely to have survived than those transferred to the government care centre or an NGO (p=0.004). However, this survival came at a financial cost five times higher than the cost of the original long-stay hospital care and 12 times higher than an NGO.

Factors that led to the tragedy were lack of financial protection, an under-estimation of the vulnerability of PLWMI, and a misinterpretation of what constitutes community-based mental health services.

However, the assumption that PHC facilities had the capacity to manage dementia, psychosis and bipolar disorder is consistent with the NDoH health indicators for PHC.29 Additionally, the resourcing of specialised psychiatric hospitals and a lack of specialist support at district level is consistent with the hosp-centric provision for psychiatric care in the National Health Insurance (NHI) White Paper.1

Some general hospital psychiatric units have been established in Gauteng. More geographically accessible and less stigmatising than psychiatric hospitals, these are better positioned for UHC. However, a high workload, poor continuity of care with community-based services, frequent readmissions related to poor medication adherence, and an unfavourable nurse:patient ratio have been described in one such unit.30 An exploratory study among nurses at the same unit revealed significant nursing stress, partly related to the severe aggression among inpatients, and partly to a lack of senior management support. This situation is described further in the case study at the end of this chapter.

Rural areas are particularly under-resourced, and possibilities for task-shifting and remote supervision using tele-psychiatry have been considered to improve mental health care services.31,32 However, task-shifting is not a panacea. An adequate human resource mix is required, with enough mental health professionals to provide training and continued supportive supervision. In North West, the integration of SMI into PHC is hampered by a lack of community-based psychiatrically trained nurses and the remoteness of specialist supervision, which is based at the psychiatric hospital.21 In KwaZulu-
This may be related to the Prescribed Minimum Benefits, which care, with average length of stay as the only health indicator. Both is a lack of financial protection for PLWMI and their service needs. Private sector care prioritises acute hospitalisation. Underpinning sector care is predominantly in poorly resourced institutions, and far short of UHC, the Convention on the Rights of Persons with Disabilities, and the Constitution. Both are hospice-centric; public health sector caters for PLWMI with either limited functional impairment or substantial family support. It follows that the prevention of psychosocial disability, through early identification, treatment and rehabilitation of SMI, and maintenance care to control symptoms and prevent relapse would be prioritised. However, the Council of Medical Schemes only reports on mental institution acute inpatient care, with average length of stay as the only health indicator. This may be related to the Prescribed Minimum Benefits, which prioritise brief acute hospitalisation for PLWMI, with an alternative option of limited outpatient psychotherapy for selected disorders. Ambulatory preventive, rehabilitative or palliative mental health care is not financially covered, not even for schizophrenia, a severely disabling, chronic, relapsing psychiatric disorder.

In summary, both public and private sector care for PLWMI fall far short of UHC, the Convention on the Rights of Persons with Disabilities, and the Constitution. Both are hospice-centric; public sector care is predominantly in poorly resourced institutions, and private sector care prioritises acute hospitalisation. Underpinning both is a lack of financial protection for PLWMI and their service needs.

Policy and plans for mental health in South Africa: 2012–2018

Following the launch of the National Development Plan: Vision for 2030, with its call for a “long and healthy life for all South Africans,” the NDoH endorsed the NMHPF, integrated mental health into general health policies and plans, and established routine indicators for mental health in general data collection (Table 1). The commitment to improved coverage of mental illness and integration of mental health into general health services is not in question. However, service provision does not appear to reflect this commitment. Now, in the early stages of NHI, is a good opportunity to consider factors in policy and plans that may hinder or advance UHC of SMI.

Private health sector

As access to private health care requires employment-linked medical scheme membership and personal financial resources, the private health sector caters for PLWMI with either limited functional impairment or substantial family support. It follows that the prevention of psychosocial disability, through early identification, treatment and rehabilitation of SMI, and maintenance care to control symptoms and prevent relapse would be prioritised. However, the Council of Medical Schemes only reports on mental institution acute inpatient care, with average length of stay as the only health indicator. This may be related to the Prescribed Minimum Benefits, which prioritise brief acute hospitalisation for PLWMI, with an alternative option of limited outpatient psychotherapy for selected disorders. Ambulatory preventive, rehabilitative or palliative mental health care is not financially covered, not even for schizophrenia, a severely disabling, chronic, relapsing psychiatric disorder.

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Community-based mental health services

National Health Insurance will provide for psychiatric care in hospitals, from regional level and above. Because they are stand-alone, specialised psychiatric hospitals are the only service to have dedicated mental health funding. In the case of community-based mental health services, NHI includes them as a PHC service. However, the intervention pyramid of the NMHPF positions them at a specialist service level, back-to-back with general hospital psychiatric units. The NMHPF further recommends that human resources of community-based mental health services are scaled up to match the NDoH norms for a specialist-level multidisciplinary team. Therefore, these are specialist-level services which operate in the community rather than the hospital setting.

The NMHPF organisation of services is consistent with the “balanced care model,” whereby community-based mental health services are the mainstay of psychiatric care, with general hospital psychiatric units providing acute symptom relief. Organising psychiatric services in this manner is recommended for middle-income countries as it facilitates task-sharing and collaborative care. Additionally, through inter-sectoral collaboration with local non-health and non-
government sectors, community-based mental health services enable a favourable environment for PLWMI and promote population mental health and well-being. By being accessible and person-centred in their approach to care, community-based mental health services fulfill the Convention on the Rights of Persons with Disabilities and the Constitution, and facilitate UHC for PLWMI. It is however uncertain if such services, if they are perceived to be a function of PHC, will be adequately financed under NHI.

The NDoH Annual Performance Plan 2018/19–2020/21 does not include community-based mental health services. However, it includes District Specialist Mental Health Teams, forensic mental health, and primary mental health care under the PHC programme, which is allocated 0.6% of the total health budget. Other PHC services competing for the same budget include all diseases except those of the priority programmes, PHC trauma and emergency medicine, oral health, nutrition, and environmental and port health. Although the PHC budgetary allocation for non-communicable diseases is to be increased over the next three years, budget allocated to professional-level salaries will be reduced, suggesting that the human resource posts required for the District Specialist Mental Health Teams are unfunded. While there is a short-term allocation from the NHI personal services grant to address the backlog of forensic psychiatry and community-based mental health services, this is a temporary arrangement which does not seek to correct the chronic systemic failures.

For quality assurance of psychiatric care, national health indicators are hospice-centric, monitoring admission rates, involuntary admissions, average length of stay, and inpatient deaths. Of concern is that there is no post-discharge monitoring, although the first year after discharge presents the highest risk period for mortality of PLWMI. There are no health indicators for community-based mental health services, no monitoring of illness relapse or adverse incidents among community-dwelling PLWMI, and no user-level outcome measures.

In summary, although NHI promises to align public and private health sectors in delivering an evidence-based package of mental health

#### Table 1: Mental health in national policies and strategic plans, South Africa, 2012–2018

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<thead>
<tr>
<th>Policy</th>
<th>Inclusion of mental health</th>
<th>Monitoring</th>
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<tr>
<td>Integrated School Health Policy 2012⁴³</td>
<td>Screening and treatment of mental health conditions made a school health requirement.</td>
<td>Mental health screening included in the school health tick register for all learner categories²⁹</td>
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| Strategic Plan for the Prevention and Control of Non-communicable Diseases 2013–2017³⁸ | Recognises the high prevalence and disability burden due to mental illness and its association with lifestyle health risk factors. The 10th target is to increase the number of people screened and treated for mental illness by 30% by 2010. | Household surveys:  
  - SANHANES–1³⁹ measures psychological distress, trauma exposure and post-traumatic stress disorder  
  - National Income Dynamics Study⁴⁰ measures depressive symptomatology |
| National Mental Health Policy Framework and Strategic Plan 2015–2020¹⁵ | Adapts the WHO Mental Health Action Plan to South Africa. Outlines areas for action with eight specific objectives. | Mental health included in general hospital data and psychiatric hospitals:²⁹  
  - average length of stay  
  - bed occupancy rates  
  - mental health separations  
  - involuntary admission rates  
  - inpatient deaths |
| Health Strategic Plan 2014/15 to 2018/19¹¹ | Promises to “scale up decentralised integrated primary mental health services which include, community-based care, PHC clinic care and district level hospital care”. Strategic objectives include improving access to mental health services, with a target of screening and treating 35% of the prevalent population. | Mental disorder screening and treatment rates included at PHC level:  
  - depression, anxiety, dementia, psychosis, mania, suicide, developmental disorders, behavioural disorders, and substance use disorders²⁹ |
| Ideal Clinic Programme⁴² | Subcomponent 16 includes availability of mental health and allied health practitioners in integrated clinical service management. | Element 31: 35% of all PHC patients screened for mental illness.  
Element 110: Patients have access to mental health services.  
Checklist for patient records: state examination. |
| National Health Insurance (NHI) White Paper, 2017⁷ | Recognises the burden of disease due to mental illness. Mental health to be prioritised in early stages of the fund. Community-based mental health at PHC level. Psychiatry included in general regional, tertiary, and central hospitals as well as specialised hospitals. Mental health included in Adult Primary Care⁴⁴ and at all service levels in the NDoH Standard Treatment Guidelines and Essential Medicines List.⁴⁴ | Guideline adherence and availability of essential psychotropic medicines. |
| NDoH Annual Performance Plan 2018/19 to 2020/21⁴⁵ | Aligned with Sustainable Development Goal 3: to promote mental health and well-being. Mental health and forensic mental health included under PHC, non-communicable diseases sub-programme; strengthen district mental health. NHI Grant: Personal Services Component to include strategic purchasing of services from psychiatrists and psychologists. | Re-engineering of PHC and inter-sectoral collaboration.  
Number of District Specialist Mental Health Teams established.  
NHI Grant:  
  - Number of psychiatrists and clinical psychologists contracted  
  - Number of people screened and treated for mental health problems  
  - Percentage reduction in the backlog of forensic mental observations |
care with a comprehensive PHC approach, it does not cover the provision of specialist level community-based mental health services, and hospice-centric psychiatric care is still prioritised. Given that South Africa has a largely deinstitutionalised mental health system, the lack of financial protection for community-based mental health services is inexplicable. As made apparent by the GMHMP, it is not possible to provide accessible care for community-dwelling PLWMI appropriate to the level of severity of illness without funding. The funding of community-based mental health care should be equal in magnitude to funding of institutional care. However, the financial burden of community-based care may be borne by multiple stakeholders, and it is believed to be more cost-effective than institutional care in that it achieves improved mental health coverage, psychosocial functioning, and quality of life among PLWMI.

Conclusion

Notwithstanding South Africa’s human rights-based Constitution, health legislation and international treaties, the country could continue denying accessible care to PLWMI under current NHI policy. By not acknowledging and financing community-based mental health services as a multidisciplinary psychiatric service, the Mental Health Care Act and NMHPF remain unfunded mandates. For PLWMI, UHC is complicated by the functional impairment of those needing care. A health system which restricts specialist care to hospitals will perpetuate psychosocial disability. Promotive, preventive, curative, rehabilitative and palliative mental health care may remain inaccessible to those most in need.

Recommendations

The following recommendations could be catalytic in achieving UHC for PLWMI:

➢ A paradigm shift in the organisation and financing of mental health services is needed, so that specialist staffed community-based mental health services become the mainstay of psychiatric care, with support from general hospitals for acute admissions and specialised hospitals only for those with the most severe mental impairment. Thus, ambulatory, preventive and promotive care should be prioritised, with an inter-sectoral collaborative approach and support of integrated primary mental health care. In the rural setting, where specialist staff are scarce, funding of technology should be included, such as that needed for tele-psychiatry, in order to facilitate remote specialist support.

➢ A mental health workforce should be developed within PHC and community-based mental health services. All nurses should receive basic training in psychiatric nursing. While posts must be developed for community-based multidisciplinary teams according to the NDoH norms manual, posts for other practitioners such as clinical associates, registered counsellors, lay health workers and lay counsellors need to be included to enable task-sharing.

➢ A national programme guideline describing pathways to care for PLWMI, with consideration of scope of practice, task-sharing duties, the NDoH standard treatment guidelines, and requirements of the Mental Health Care Act is needed. Inter-sectoral duties must be delineated according to service-
References


