



The art of medicine

The moral case for global mental health delivery

Poor people die much earlier than rich people. Objection to this injustice is the foundation of global health equity that seeks to redress disparities of risk and outcome within and between populations. Many strategies are needed to address this injustice, and many of them target the structural violence that is committed on people who wield less power and wealth. This essay concerns not actions targeting these structural determinants, as crucial as they are. Instead, we explore the risks of potential collusion of the global health community with this injustice, played out on both global and local stages.

The starting point of even unwitting collusion stems from the unquestioning acceptance of the terms of debate set by academics, policy makers, and health authorities. Whenever we call for care for poorer inhabitants of poor communities to be restricted to what is cost-effective, where the effectiveness metric is set at mortality or the relatively abstract notion of a disability-adjusted life-year, interventions for conditions as complex, distressing and enduring as schizophrenia, dementia, or autism are weighted against those for malaria in terms of “best buys” and “value for money”. Such a narrow framing of human suffering is an immoral rationale for the discouragement or outright denial of care for people with conditions whose interventions are deemed not to be cost-effective.

We work in diverse disciplines of global health, but all of these share one common theme: injustice to the poor, and poorer countries, in relation to their access to quality care we know can transform their lives. The right to life-saving and life-transforming diagnostic and therapeutic interventions should be based on whether or not these tools exist in a global economy rather than a narrow economic calculus based on the gross domestic

product of a country or on the supposed economic value of relieving suffering caused by a specific pathology. Because we have long lived in a global political economy, and within innumerable local moral worlds, we argue that demonstrably effective remedies in one corner of this global village are not meant to be held up in customs. The moral driver of global health delivery is simple: the benefits of high-quality health care must be made available and accessible to all people, irrespective of their social station or where they live.

Despite the ultimate global response to the HIV pandemic, which represented a transformative example of the power of this moral argument, injustice continues to be perpetrated against people with other kinds of health problems. An outstanding exemplar of this injustice is that of the outcomes of people affected by severe mental disorders and disabilities, ranging from autism and intellectual disability in childhood to chronic psychoses in adults to dementia in older people. The devastating consequences of these chronic conditions are often determined by the intersection of deprivation, exclusion, and discrimination, fuelled by the insufficient quality care for their mental health and coexisting physical health problems. All of these incur profound costs, almost entirely met by the affected person and their families.

Severe mental disorders and disabilities are not, themselves, lethal conditions, yet people with these conditions die much earlier than others in their communities. In some places, they live half as long. One of the reasons for this premature mortality is the poorer quality of care for cardiometabolic conditions that often accompany mental health conditions. In 2018, WHO published guidelines on reducing premature mortality in people with severe mental disorders and, after synthesising the published evidence, recommended better quality clinical care for tobacco cessation, diabetes, and cardiovascular disease. While such guidelines are welcome, details of the delivery of these services need to be refined to reflect great global variation in health care and payment systems. This requires more implementation evidence, of course, and much concerted action.

That said, these guidelines highlight the problem with achieving global health equity for people living with such chronic conditions and that is how certain forms of evidence of effectiveness of interventions are privileged over others. In the case of the WHO guidelines, for example, evaluations of clinical interventions and aggregated data of groups of patients randomised in trials trump the lived experience of mental health problems. Not surprisingly,



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although we know that quality care of severe mental disorders relies on a person-centred mix of medications and a range of psychosocial interventions enshrined in a rights-based framework of dignity and freedom, only the former comes close to any acceptable threshold of cost-effectiveness and, even then, only if the oldest and cheapest medicines are being used. Here, we encounter yet another canard, wherein cost is conflated with price, even though prices for commodities vary widely, as we have seen so dramatically with antiretroviral medications.

When viewed through this narrow prism, psychosocial and rights-based interventions are typically devalued. Given what we now know about the lethal consequences of coercion, social isolation, and exclusion and the positive impacts on life expectancy of freedom, social networks, dignified work, and decent housing, why do we not consider these as targets for interventions, on a par with improving cardiometabolic health, when they are all too common accompaniments to the lived experience of severe mental disorders and probably contribute to a considerable share of premature mortality? Will we have to wait for someone to run a randomised controlled trial with an economic evaluation to support the intervention of befriending, supported decision making, inclusion in the work-place, or decent housing before we acknowledge these as being worthy investments for health-care systems?

Moral arguments continue to be dismissed or undervalued in priority setting in global health. Instead, questions such as the burden of disease and cost-effectiveness that are predicated on the uncontested assumption that resources are constrained for strategies intended to achieve equity—but not for those intended to create more wealth for the already wealthy or to wage war—or that the primary locus of interventions for health-care problems is narrowly defined technological fixes, from bednets and vaccines to clinical treatments, dominate conversations on what decision makers should prioritise for resourcing. In the end, this approach pits those championing one disease against those championing another, each side trying to highlight the numbers of those affected or the proportion of the burden attributed to that condition, or the economic consequences of the condition, or the “value for money” to invest in interventions for that condition. Although the calls for a massive increase in investment in universal health coverage are a welcome step to realising the aspiration of quality care for all people and for all health conditions, they are still voices in the wilderness when compared with the economic arguments that continue to claim that the world cannot afford such care. These arguments fail to challenge the status quo fuelled by the increasing commercialisation and medicalisation of all aspects of health care, which is driving up costs. Moreover, this economic case neglects

the already small and steadily shrinking budgets for the social sector, fuelled by policies that are propelling further widening of disparities and the failure to scale up low-cost, high-quality delivery strategies such as community health workers and to integrate social care interventions with health-care delivery.

We will need to reframe the appalling fact that most people with severe mental disorders and disabilities die earlier than they should simply because they do not have access to quality and person-centred care as a moral outrage, no less an insult to our basic humanity than the arguments that people with HIV in Africa could be left to die because their countries’ health systems were weak or the interventions unaffordable. To do so, global health delivery practitioners will need to adopt a rights-based approach to health care. This approach demands that people with the lived experience must be at the centre of decision making about which interventions should be prioritised. Interventions should cover both clinical and social aspects of the condition and they must be delivered with the full participation of the person affected, and those interventions that have a strong association with improved health and social outcomes must be resourced to reach the last mile. In line with this approach, we need to reframe the conversations on the neglect of mental health beyond advocating for scaling up evidence-based interventions and concurrently emphasise the right to quality care, free from any form of coercion that is fundamentally incompatible with rights-based care, and the need to address the social determinants that accompany mental health problems.

People with severe mental disorders and disabilities were subjected to horrific forms of torture and violence under the guise of mental health care for centuries and were among the first victims of the Nazi gas chambers. In our times, these individuals have been cast aside to sleep on the streets of cities of unimaginable wealth, or to be incarcerated in prisons, or kept in captivity in colonial-era asylums and religious healing shrines. Our collective failure to respond to the needs of one of the most vulnerable groups of people in society is a catastrophic failure of humanity. It is this humanity to which we must appeal to address this global injustice. The aspiration of universal health coverage cannot be met solely through considerations of what constitutes good value for money, but what is good value for humanity.

*Vikram Patel, Paul E Farmer

Department of Global Health and Social Medicine, Harvard Medical School, Boston, MA 02115, USA (VP, PF); Harvard T H Chan School of Public Health, Boston, MA, USA (VP); Sangath, Goa, India (VP); Division of Global Health Equity, Brigham and Women’s Hospital, Boston, MA, USA (PF); and Partners In Health, Boston, MA, USA (PF) vikram_patel@hms.harvard.edu

Further reading

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