RESEARCH REPORT

BasicNeeds

BasicRights

Financing Mental Health Care in Ghana

POLICY STUDY

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LIST OF ACRONYMS

BN	BasicNeeds
CMS	Central Medical Store
CPN	Community Psychiatric Nurse
DANIDA	Danish International Development Agency
DfID	Department for International Development
FGD	Focus Group Discussion
GHS	Ghana Health Service
GoG	Government of Ghana
IGF	Internally Generated Funds
MoFEP	Ministry of Finance and Economic Planning
MoH	Ministry of Health
NGO	Non-Governmental Organisation
OPD	Out Patient Department
PPME	Policy Planning, Monitoring and Evaluation

SUMMARY

Financing is vital for any health system to function effectively and to deliver good quality health services. Unfortunately in the mental health sector, it is plagued with inadequate resources leading to irregular supply of psychotropic medicines, poor/lack of infrastructure and few mental health professionals in Ghana.

Funding for mental health is drawn from the same source as the general heath sector, mainly, government, Internally Generated Funds (IGF) and from donors. Whereas other sectors of health and health institutions such as the general hospitals generate funds to supplement the limited resources allocated by government, mental health sector, especially the psychiatric hospitals generate almost no funds, as policy dictates.

Government funding for mental health has been slow and erratic as evidenced from records of government funding allocation to the mental hospitals over the last five years. Apart from scarcity of resources for the health sector, low level of advocacy and lobbying by mental health professionals, low prioritisation for mental health by health authorities and government and perception that other areas of the health sector are most important than the mental health sub-sector pose obstacles to adequate financing of the mental health sector. In addition, apart from the three psychiatric hospitals, government does not allocate specific budget allocation to mental health in the regions and districts.

The impact of low budgetary allocation is obvious; people with mental illness and their primary care-givers have to pay out of pocket for their medicines or go without medications which increase the rate of relapse.

There have been calls for effective lobbying by mental health professionals, individuals and other civil society organisations interested in mental health for improved prioritisation for the mental health sector. In addition, there is the need for such groups of people mentioned above to collaborate and ensure key decision-makers are influenced to adequately finance scaling up of mental health and development services for the population. This will be best facilitated if there is a law on mental health in the country, hence the need for the mental health bill to be enacted into law.

1.0 INTRODUCTION

Finance is a critical factor for any health system to deliver quality services. Through BasicNeeds work in Ghana, there is increased recognition that psychotropic medicines, mental health professionals and infrastructure for mental health services are heavily dependant on adequate financing. Allocating adequate financial resources provide an enabling environment for the delivery of good quality mental health services, effective training of human resource, infrastructure development and so making mental health services to a majority of people who require such services but which at present are highly inaccessible.

In Ghana, there are few mental health professionals, frequent shortages of psychotropic medicines, poor infrastructure for consulting people with mental illness among others and an engrained stigma about mental illness or epilepsy. The situation in which there are inadequate government resources for mental health has led to BasicNeeds to provide funding for procurement of medicines to supplement the ever-inadequate stocks as well as facilitate and support the delivery of mental health services to regions and districts through specialist psychiatric clinic and other community based services in many deprived areas of part the country the organisation works in.

Over the years government has tried to address the problem of mental health by enacting legislation on mental health. The current mental health bill, which aims to promoting access to basic mental health care in the least restrictive environment, integrate mental health into Primary Health Care (PHC) and to de-institutionalise mental health (Draft Mental Health Bill, 2009). However, efforts at getting the bill enacted into a legislative instrument are yet to pay off.

BasicNeeds seeks is undertaking this research to unravel and understand government financing of the mental health sub-sector as part of efforts of ensuring mental health is made adequately accessible to majority of the people at appreciable reasonable quality.

1.1 Justification

BasicNeeds stands out as the only international NGO that implements programmes in mental health in Ghana.

Mental health financing in Ghana has been a huge bottleneck for mental health administrators and for civil society. In the course of our work in Ghana, BasicNeeds has come to realize that the challenge posed by the inadequacy of mental health financing appears insurmountable. Psychotropic medicines, human resource and infrastructure for mental health services depend on availability of funding (Appiah-Kubi et al., 2007). As a result of inadequate funding for the mental health sector, BasicNeeds has had to support in the purchase of psychotropic medicines, training mental health staff as well as training general health nurses to provide support to the few mental health professionals in the country.

In view of this, the sub-sector is not attractive to newly trained doctors and nurses and they therefore shy away from Psychiatry. This goes to explain why BasicNeeds is in a better placed position to conduct this study.

1.2 Profile of Ghana

Ghana's land area is 238,538 sq. km in size, and is located on the West Africa's Gulf of Guinea only a few degrees north of the Equator. Ghana has a population of about 20 million. The mainstay of Ghana's economy is agriculture. Agriculture contributes about 42.5% to the GDP, followed by services (32.5%) and industry (25%). Ghana's economic development has been uneven over time since independence. In the fifties Ghana experienced rapid economic growth. However, in the early

sixties the economy experienced serious decline. The economic down-turn continued until the early eighties, when the then government in power introduced an economic recovery programme, through the Structural Adjustment Programmes (SAPs) of the World Bank and the International Monetary Fund (IMF). Even though the programme succeeded in reversing the downward trend in the economy, with a per capita income of about US$420 poverty still remained very high in Ghana.

Ghana is a low-income country. About a third of its population live below the poverty line though well endowed with natural resources and with roughly twice the per capital output of poorer countries in West Africa

Ghana has an ethnic diversity of about 100 linguistic and cultural groupings with the major blocks being; Akan 44%, Mole-Dagomba 16%, Ewe 13% and Ga 8%. The official language is English, but Twi, Ewe, Ga, and Dagbani are widely spoken. Administratively, the country is divided into 10 regions and 170 districts, municipalities and metropolis. The regions and districts have a degree of autonomy and self-government in accordance with the local government law and decentralisation policy of government. The country is relatively politically stable. Close to 70% of its population still dwelling in the rural areas.

1.3 Profile of Pantang Hospital

Pantang Hospital is the largest and one of the only three Psychiatric Hospitals in Ghana. The hospital is located near Pantang Village in the Ga East District in the Greater Accra Region. The hospital is 1.6km off the main Accra-Aburi trunk road and about 26km from the Central Business area of Accra.

The hospital was commissioned in 1975 while only partially completed as a regional Psychiatric Hospital with a bed capacity of 500. There are 28 operational departments. The hospital provides a 24 hour psychiatric and 12 hour physical services at its two distinct psychological and physical out-patients departments. The hospital receives psychiatric patients from all over Ghana and a few from neighbouring countries, namely Togo, Benin, Burkina Faso, Ivory Coast and Nigeria. There are ten (10) admission wards (seven male and three female) and each ward can accommodate fifty (50) patients.

The out-patients department (O.P.D) provides free psychiatric services. It also offers Primary Health Care and Maternal and Child Health to over 15 villages in its catchment area on a cash and carry/National Health Insurance Scheme basis with exemption for the aged, pregnant women, children under five (5) years and people suffering from tuberculosis.

The Ministry of Health has a Nursing Training College at the hospital for a three year Diploma course in Mental Nursing. The hospital also provides ten weeks affiliation training in mental health for nursing student from both government and Mission Hospitals.

1.4 Profile of the Accra Psychiatric Hospital

The hospital is located on the Castle Road at Adabraka-Accra in the Osu Clottey constituency of the Greater Accra Region. Adjacent to the hospital is the Holy Spirit Cathedral and opposite it is the Adabraka polyclinic.

From the colonial days when mentally ill persons were left to their fate and given little health care, the present Accra psychiatric Hospital was commissioned in 1906 to accommodate 200 patients. The bed capacity of the hospital now stands at 600, even though the hospital currently has 1200 patients on admission. The hospital has 23 wards made up of 16 male wards and 7 female wards.

There are 16 operational departments. The hospital provides services to patients from all the regions of the country including neighbouring countries.

There is one training facility, except that it is ill-equipped.

2.0 LITERATURE REVIEW

2.1 The Global Picture of Mental Health

The World health Organisation (2001) reported that mental illnesses are common and that more than 25% of people suffer from it in their life time. WHO also estimated that in 1990, mental disorders accounted for 10% of the total Disability Adjusted Life Years[1] (DALYs) lost due to all diseases and injuries. This increased to 12% in 2000 and is expected to reach 15% by 2020. Low and middle-income countries like Ghana will share in this burden.

2.2 The burden of mental ill-health

Mental and behavioral disorders are estimated to account for 12% of the global burden of disease, yet the mental health budgets of the majority of countries constitute less than 1% of their total health expenditures. The relationship between disease burden and disease spending is clearly disproportionate. More than 40% of countries have no mental health policy and over 30% have no mental health programme. Over 90% of countries have no mental health policy that includes children and adolescents. Moreover, health plans frequently do not cover mental and behavioral disorders at the same level as other illnesses, creating significant economic difficulties for patients and their families. And so the suffering continues, and the difficulties grow (WHO, 2001 p. 4). So clearly, mental health continues to be given least priority in global health. The global distribution of resources for mental health shows great inequalities between rich and poor countries, and further inequalities in poor countries. The overwhelming majority of people, even with severe mental disorders, in poor countries do not receive good mental health care. This is despite the evidence for the effectiveness of relatively cheap drugs and psychosocial treatments.

2.3 Mental health Situation In developing countries

The presence of mental health policies and programmes in general was not associated with the proportion of health budget allocated to mental health. Countries categorized based on the proportion of mental health budget to health budget differed significantly in terms of policy on disability benefits and mental health resource indicators (beds, personnel, services for special populations and availability of drugs).

The perceived importance of physical health as opposed to mental health as a priority in developing societies serves to restrain the growth of mental health systems. Perhaps, it is related to standards for assessing health status in developing societies in terms of infant mortality, control of infectious diseases and population growth rather than in terms of disability and psychological well-being. Societies, especially those in developing countries like Ghana have not taken time to accept that mental disorders have public health importance. Only the most favoured groups in the society find their needs on the national agenda. And in that competition, the needs of other segments command greater public appeal than the problems of the mentally ill. Besides, mentally ill people are also the least likely to protest.

2.4 Mental Health Situation in Ghana

There have not been any statistical estimates about the number of people suffering from neuropsychiatry disorders in Ghana. However, based on the World Health Organisation estimates

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[1] In 1993 the Harvard School of Public Health in collaboration with the World Bank and WHO assessed the Global Burden of Disease (GBD). GBD also introduced a new metric – disability- adjusted life year (DALY) – to quantify the burden of disease. The DALY is a health gap measure, which combines information on the impact of premature death and of disability and other nonfatal health outcomes. One DALY can be thought of as one lost year of 'healthy' life, and the burden of disease as a measurement of the gap between current health status and an ideal situation where everyone lives into old age free of disease and disability.

of people suffering from mental illness, some extrapolation can be made for Ghana. Thus, Ghana with a population of about 20,200,000 may have 202,000 people who may suffer from neuropsychiatry conditions and severe mental disorders. As at June 2009, BasicNeeds Ghana had reached out to 17,462 people with mental illness and epilepsy in four regions in Ghana.

"Currently, mental health service in the country is provided by a number of organizations. There are the public specialized institutions which are the three psychiatric hospitals at Accra, Pantang and Ankaful near Cape Coast. In addition, there are also three private institutions in Accra, Tema and Kumasi which treat mental illness. These are manned by specialists and consultant psychiatrists.

Moreover, there are the public community services provided by the psychiatric wings of some health centers, polyclinics, district and regional hospitals and they are manned by community psychiatric nurses and specialist psychiatrists. Most of the general hospitals also treat mental disorders and refer as necessary.

Furthermore, there are some orthodox facilities owned by missions that also treat mentally ill people. Damien Centre in Fijai near Takoradi, Cheshire Home in Kumasi and Mercy Centre at Brafo Yaw near Cape Coast, Remar Centre in Accra and Kumasi are examples.

Traditional healers who treat mental illness are practically everywhere in the country. Similarly, faith-based healing camps abound and are scattered everywhere.

Even though there are a number of providers in the service of mental health care, these institutions are only limited to the south. Therefore people have to come from all over the country for residential treatment or long term stay. Even with the current mental health service providers, they are inadequate in terms of their numbers and even style. The Accra Psychiatric Hospital for instance was built as an asylum and hence it still retains its architecture of a prison. There is no proper Outpatient Department, no recovery ward in any of the three hospitals, and this actually also contributes to the congestion. For instance a patient who could have been detained for one or two days, is admitted and remains on the wards for months. There are not enough bedsteads. Again, the Accra Psychiatric Hospital has 1200 patients on admission yet it has only 400 beds. The few beds available have do not have adequate beddings – mattresses, blankets and bed sheets". (Yaro, B. P., et al., 2005 p. 1-2)

The Ghana Health Service (the mental health unit) is responsible for has been mandated by the government of Ghana to regulating and monitoring psychiatric care in both private and traditional/spiritual setting in the country.

"In Ghana, Mental health is part of the primary health care system. Actual treatment of severe mental disorders is available at the primary level. There are community care facilities for patients with mental disorder, and community Psychiatric Nurses are available. There are also 'healing churches' which help in community care, few half-way houses and charitable institutions also help in community care. Informal community care plays an important role in psychiatric management. There is a mental health reporting system in the country. However the data collected are not reliable and are not utilized for system development" (WHO, 2005 p. 205.) Is however true to say that data in terms of causes for admissions and discharged are readily available in the hospitals. For instance, Substance-abuse-related admissions at the Pantang hospital in 2007 totaled 52.1%, whilst alcohol-related admissions came up to 21.5% (Presentation on Pantang Hospital: Nov 2007)

In Ghana, there are budgetary allocations for mental health. The country spends 0.5% of the total health budget on mental health (WHO, 2005 p. 209).

2.5 Mental Health Financing

"Mental health financing is a powerful tool with which policy-makers can develop and shape quality mental health systems. Without adequate financing, mental health policies and plans remain in the realm of rhetoric and good intentions." (WHO, 2003 p. 2)

Financing is a system through which plans and policies are translated into action. This is achieved by way of allocation of resources. As an important factor for the implementation of a sustainable mental health programme, funds are needed as a resource base for operation and service delivery, the improvement and deployment of trained human resource and for the building of needed infrastructural and technological know-how.

The World Health Organization, (2003, p. 2) mentions some eight ''steps for discussing mental health financing: these include the following:

- Understand the broad health care financing context
- Map the mental health system to understand the level of current resources and how they are used.
- Develop the resource base for mental health services
- Allocate funds to address planning priorities
- Build budgets for management and accountability
- Purchase mental health services to optimize effectiveness and efficiency
- Develop the infrastructure for mental health financing
- Use financing as a tool to change mental health service delivery systems

In order to understand the context within which mental health financing occurs in Ghana, it will be prudent to know the mechanisms for raising revenues: This include taxes, user charges, borrowing, etc. Whereas in countries such as the United States where healthcare is jointly financed by federal and state (or provincial) governments, in Ghana the general tax approach is used where the government collects various kinds of taxes. It is relevant to observe that besides public financing of mental health in Ghana, other sources include private individual payments but this is of lesser importance. In essence therefore the commonest method for financing mental health is tax-based funding, and to a less extent out-of-pocket payments. In Ghana, as in other developing countries, Individuals with mental disorders are commonly poorer than the rest of the population and less able or willing to seek care because of stigma or previous negative experiences of services. As a result, payment out of their own pockets or their families' pockets is constitute an obstacle to care compared to payment for many acute physical health problems. At Pantang Hospital in Ghana, payment out of pocket which is considered as part of internally generated funds is inadequate. Meanwhile, "The release of funds has been inadequate and irregular. This leads to a handicap in our ability to deliver" (A paper presented by Pantang Hospital during discussions for the Programme of Works 2008)

2.6 Mental Health Resource(s) Allocation

There is some literature that categorizes countries into two - those that make less budgetary allocation to mental health and those that spend more on mental health care as percentage of total health budget. For example Malaysia spends 1.5% of its total health budget on mental health. China spends 2.35%, South Africa 2.7%, Australia 6.5% and New Zealand 11% and these are considered as high (WHO 2001a). The World Health Organization, (2003) mental health financing report cited India as a country that spends a lowly 0.83% of total health budget on mental health. Pathare, (2005) observed that: "It is difficult to know the exact break-up of spending, as India does not have a separate mental health budget. However, details of mental health spending are available for one Indian state, Gujarat . In Gujarat , the total allocation towards mental health works

out to Rs 82 million out of a total health budget of Rs 8,562 million. Of this Rs 82 million, Rs 37 million is spent on mental hospitals, Rs 34 million on medical colleges (presumably departments of psychiatry in medical colleges) and Rs 5 million on district hospitals. It appears that Rs 2.15 million under 'central sponsored schemes' is the only outlay on a community programme. About 67% of the total expenditure is on salaries and 20% on medicines and supplies". (Pathare, 2005)

2.7 Lack of Separate Budgets for Mental Health

Mental health financing is not an isolated activity but occurs in widely disparate political and economic contexts and, often, within the context of more general health care financing. Indeed, in many countries, including Ghana, mental health financing is subsumed under more general health financing and is often not distinct. In many cases it is shaped, if not determined, by the objectives of general health care financing. For example, the five year programme of works and the budgets of the country over the years and/or health performance reports

In an article Saxena, et al., (2003) observed that there are some merits in having a separate budget for mental health. The article identifies common methods of financing mental health care as tax-based funding, social insurance and out-of-pocket payments, and make the point (which is true of Ghana as well) that individuals with mental disorders are commonly poorer than the rest of the population and less able or willing to seek care because of stigma or previous negative experiences of services

The article showed that 32% of 191 countries did not have a specified budget for mental health. Of the 89 countries that supplied the requisite information 36% spent less than 1% of their total health budget on mental health. Many countries from Africa (79%) and the South East Asia (63%) were in this subgroup. In comparison with the Global Burden of Disease data showed a marked disparity between burden and resources allocated to address the problem. The primary method of financing mental health care in most countries was tax-based (60.2%), but many low-income countries depended on out-of-pocket expenditure (16.4%). Indeed, the WHO affirms that the primary source of mental health finance in Ghana is tax-based (WHO mental health atlas 2005 Pg 209)

2.8 Economic Barriers to Improving Mental Health Care

Knapp, et al., (2006) discussed the economic barriers to improving the availability, accessibility, efficiency and equity of mental health care in low- and middle-income countries and identified some six sets of barriers, namely information barrier, resource insufficiency, resource distribution, resource inappropriateness, resource inflexibility and resource timing.

In order to overcome the barriers the authors made some suggestions, which they put as improving mental health literacy, tackling stigma, improving financing mechanisms, prioritizing and protecting mental health care budgets, emphasizing mental health promotion, exploring routes to improved equity, experimenting with new arrangements for purchasing and delivering services, improving coordination between agencies and professionals at both macro- and micro-levels, building alliances between public and private sectors, and training and mobilizing primary care services to improve identification and treatment of mental health problems.

It is conceded that increasing the resources available for mental health care would certainly not remove all of the barriers, but it would represent an important start. Such an increase might be achieved through an expansion of the overall health budget, through the prioritization of mental health and/or through the protection of mental health funds via ring-fenced budgets. There are, of course, disadvantages as well as advantages in such an approach, for ring-fenced budgets can stop resources flowing *in* as well as out, and can encourage isolationism and reinforce negative images of the 'special' nature of mental illness. Knapp, et al., (2006)

In Ghana, governmental funding allocation to health had progressively nose-dived over the years since independence in 1957. Appiah-Kubi, 2006 p. 37 asserts that 'it is within the context of declining availability of real resources that mental health financing in Ghana should be situated'. It is relevant for purposes of reviewing available materials on mental health financing in Ghana to note that the focus of that study was to gauge the impact that some macro-economic factors exert on the allocation and availability of funds to mental health care delivery in Ghana.

The report looked at macro-economic variables such as budgetary deficits, structural adjustments, poverty reduction programmes, foreign aid, debt relief and debt burden and argues that ' debt servicing in most indebted developing countries takes a much larger slice of their budgets than public health and this contribute to deepen the marginalization of such already neglected health problems as mental health

The report is a worthy addition to the collection of mental health financial materials in view of its attempt to conceptualize the issues that concern mental health financing in Ghana. The report describes the health care financing context in which MH care is defined. The succinct illustration of the level of mental health resources and how they are utilized would serve as an important reference point for the current study on mental health financing in Ghana.

2.9 Impact of Mental Health Financing

Whereas the article by the World Health Organization looked at mental health financing from the angle of planning and budgeting, Dixon, et al., (2006) explored the impact of health care financing arrangements on the efficient and equitable utilization of mental health services. Through a review of the literature and a number of country case studies, the WHO publication examines the impact of financing mental health services from out-of-pocket payments, private health insurance, social health insurance and taxation and discusses the implications for the development o f financing systems in low- and middle-income countries.

Mental disorders account for a significant proportion of the burden of disease. Yet it is not given the right attention. Thus, mental health is not prioritized for public financing purposes. In many developing countries many patients pay for mental health services. This tends to aggravate an already burdensome financial situation, makes the poor poorer and limits their access to effective mental health.

2.10 Conclusion

In this review we have sought to discuss the sources, allocation and utilization of mental health funding in low- and middle-income countries, evidence from what has been said about developing countries suggests it is the case in Ghana that health care, including mental health care, is delivered in an environment of scarce resources . Global and regional campaigns by the WHO, (2003) have helped to raise the profile of mental health problems, as well as promoting best practice.

The study involved group discussions with people with mental illness or epilepsy and their primary care-givers, as well as interviews with government officials and mental health professionals. A case study that provided an opportunity to pencil in on the Pantang hospital was also documented to augment evidence for this study. There was also review of literature available on the subject.

From these methodologies employed it is expected that policy makers would seize the opportunity to show more commitment to the promotion of mental health in Ghana and in other developing countries. This expectation is against the backdrop that policy makers generally place more emphasis on mortality oriented statistics, which are rather low for mental disorders (Soltani, et al.,

2005). However, various interventions have tried to change this attitude with warnings that mental illnesses constitute up to 12% of the global burden of disease (WHO 2001, 2003) and thus deserve the attention of every individual.

3.0 THE STUDY

This study is aimed at providing BasicNeeds with relevant information on how mental health funding is sourced, allocated and utilized. It is also to help determine the impact that the current funding situation has on the delivery of mental health services.

3.1 Study Objectives

a) To identify the main sources of funding available to mental health in Ghana.
b) To understand how mental health funding is allocated and used.
c) To assess the impact of the current funding situation (including sources, allocations and sustainability) on mental health care.

3.2 Scope of the study

This study covered four sub-metros of Accra and Wa in the Upper West Region where BasicNeeds Ghana operates.

3.3 Methodology

This was both a qualitative and quantitative study that took the form of group discussions involving people with mental illness or epilepsy and their primary care-givers, as well as interviews with government officials and mental health professionals. A case study was also documented to augment evidence for this study. There was also review of literature available on the subject. Below provides further details of the processes the study took.

3.3.1 Data Sources

Five **focus group discussions** were held in Accra and Tamale with people with mental illness or epilepsy who receive mental health services at the polyclinic or psychiatric unit. A total of 75 people with mental illness and their carers participated in the discussion using a prepared topic guide to aid in the discussion. (Appendix 1)

Using a well prepared interview guide (Appendix 2&3) and matrices (Appendix 4, 5, 6&7), interviews were conducted with **thirteen key informants** in Accra and Wa. Key informants were basically made up of government officials and health professionals from mental health hospitals, polyclinics and Community Psychiatric Unit. Those interviewed included the following: (See appendix 4 for full list)

- Deputy Director, Policy Planning, monitoring and evaluation o f the Ghana Health Service;
- Medical Director, Pantang Hospital
- Chief Pharmacist, Accra Psychiatric Hospital
- Pantang Pharmacist
- Accra Metropolitan Director of Health Services
- Upper West Regional Director of Health Services
- Upper West regional Accountant of Health
- Community Psychiatric Nurses (2 from the Maamobi Polyclinic, Accra and 1 from Wa Regional Hospital)
- Medical Director of the Wa Regional Hospital
- Acting Chief Psychiatrist (He also doubles as the Medical Director of the Accra Psychiatric Hospital
- Director of Procurement and Supplies, Ghana Health Service

Research Officers also reviewed **secondary documents** such as the national budgets for fiscal years spanning 2004-2008. The annual reports of Pantang Mental Hospital, and the Ghana Health Service were also reviewed. It is relevant to indicate that annual national budgets indicate in detail government's planned revenue and expenditure for the year. The focus, in perusing the budget, was to tease out data on the allocation of funds to the health sector in general and to mental health in particular. The information gathered was used as basis for interview with hospital managers and other key health and mental health officials.

3.3.2 Process of Data Collection

Focus Group Discussion

Five focus group discussions were held in Accra one in each of the four sub-metros of Accra namely Ashiedu Keteke, Ablekuma, Ayawaso and Okaikoi. One other focus group discussion was held in Wa in the upper west region involving a total of seventy five people with mental disorders and their carers. The two Research Officers in Tamale and Accra (Truelove & Evans) jointly organized these focus group discussions. Prior to the date of the discussions, a date was scheduled with participants and a venue for the discussion was agreed. Participants were notified to participate in the FGD through community volunteers that BasicNeeds work with in the various sub-metros and districts. The community volunteers went to their homes and invited them.

Permission was sought from participants to document the discussions, take photographs, and disseminate the findings. They agreed to participate in the discussions, unanimously endorsed that photographs could be taken and that information generated from the discussion could be disseminated or shared, by signing a consent form (See Appendix D). Truelove and Evans facilitated the discussions in Accra and in Wa using prepared topic guide. The discussions were recorded by writing. In Wa, a partner field staff, Felix interpreted from English to the local language for participants.

3.3.3 Key Informant Interviews

Phone calls and personal contacts/visits were made to key informants notifying and requesting for their time for discussions. The Key informants were carefully selected from regional/referral hospitals, and from primary health care levels. In order to give the study a national character, health personnel were selected from the Greater Accra and Upper West regions.

To give the research study legitimacy it deserves, a letter was first sent to the Director General of the Ghana Health Service informing him of the study and seeking his approval for it. Conscious efforts were made by research officers not only to seek the consent of respondents prior to interviewing sessions but also that permission was sought to record the discussions and to take photos if possible. Research Officers recorded the interviews by writing down notes.

3.3.4 Case Study

A detailed case study that involved collection of data on the expenditures and utilization of funds of the Pantang hospital was conducted. The Research Officers held a preliminary meeting with the Medical Director in charge of the hospital to introduce the study. Given the focus of the study, the Medical director invited he Hospital Accountant and the Stores Manager to the meeting. Time schedules were agreed with the officers for the collection of filled in matrices for the case study. This was after the Research Officers had painstakingly taken the officers through the matrices and how they should be completed.

3.4 Relevance of the study

The outcome of the study would:

α) Inform BasicNeeds to influence mental health policy decisions in the various countries where BasicNeeds operates and where the study was conducted.

β) Serve as a bedrock activity around which a more detailed study on financing or costing future psychiatric interventions would be carried out.

χ) Contribute towards improved transparency about mental health funding sources and allocation as well as information about cost-effective mental health care options that immensely contribute to reducing the financial difficulties that plague mental health in Ghana.

3.5 Data Analysis and Report Writing

The outcomes of the focus group discussions, interviews with key informants and the Pantang case study have together provided the basis required for analyzing the field data.

Data generated from the review of national budgets and other secondary documents as well as information gathered from focus group discussions and from interviews from key informants were analyzed based on broad themes on how mental health funding is sourced, allocated and utilized and on the impact that the current funding situation has on the delivery of mental health services. Conscious efforts were made to include in the report, direct quotations in the analysis of interviews and discussions carried out as part of the study.

Truelove and Evans shared parts of the report to write on which were then consolidated by Truelove.

4.0 DATA PRESENTATION AND ANALYSIS

This chapter presents the findings of the study. These are centred on the major themes of mental health services offered, records/information systems on allocation public (government) funds for mental health, sources of mental health funding, process of allocating funding to mental health, challenges in funding allocation to mental health and sustainability of mental health funding.

4.1 Mental Health Services Offered

At Pantang Hospital, the Medical Director, Dr. Anna Dzadey mentioned that mental health services offered at the hospital for out-patients include diagnosis, prescribing medicines (pharmacotherapy), laboratory services, mental health educational talks, counselling and screening of HIV for people with mental illness. She added that mental health patients are sometimes referred to social welfare officers or a psychologist depending on the need.

These services offered are not very different from those of the Accra Psychiatric Hospital and those of the Community Psychiatric Unit in Wa and Polyclinics in Accra where the research team visited. The only differences are that in Wa, there is no psychologist so counselling is done by the Community Psychiatric Nurse and follow up community outreach clinics are undertaken by the Regional Coordinator in charge of Community Psychiatry, who is a Principal Nursing Officer (PNO). In addition, home visits are done by the Community Psychiatric Nurses at the Community Psychiatric Units or Polyclinics. In a focus group discussion with people with mental illness in Accra and Wa, they confirmed they receive mental health services such as counselling, medicines and educational talks, etc.

For in-patients at Pantang Hospital, all mental health services as mentioned above for out-patients are offered in addition to occupational therapy for rehabilitation purposes. There is a vegetable gardening project for patients, snail project and soap making activities for patients. Dr. Dzadey also disclosed that apart from these, there are meetings for alcoholics, narcotic anonymous meetings, group therapy meetings, individual meeting with the psychologist, and therapeutic meetings on the ward and physical exercise for patients.

These mental health services offered have cost implications which will be look at in detail later in this report.

4.2 Records/Information Systems for Utilisation of Mental Health Services

At all the psychiatric hospitals and the Community Psychiatric Units visited, every patient who comes for consultation has a medical file kept at the hospital in which his/her diagnosis, history of illness, habits (whether the person smokes or drinks) and other details including medicines prescribed are written. This is done through structured interview format and with the use of ICD 10[2]. A summary of each patient's information is also kept in the hospital's register. Recording each patient's visit and medications given in particular helps to make well-informed mental health decisions as to how many people are accessing and utilizing resources allocated and how to plan and budget for resources.

Another piece of information that is recorded is dispensed psychotropic medications. This is done at the pharmacy and expected to confirm what the psychiatrists or psychiatric nurses prescribe. It was observed that this is done manually which according to some of the record officers, gives room for errors and inaccurate statistics from the pharmacy department. Based on actual usage of medications, pharmacists make a projection and request for medicines from the central medical

[2] This is an international code adopted by the GHS for classification of mental health conditions.

stores using a requisition form. At the regional level, the Regional Coordinator in charge of Community Psychiatry collates returns from the districts and request on a quarterly basis medicines from the regional medical store and distributes to each district accordingly. This is slightly different from Accra where returns of medications used are made at the end of every month for the supply of new ones for the ensuing month.

The Chief Pharmacist collates information from all the regions about the use of psychotropic medicines and analyses the usage pattern in order to put together an annual budget for the procurement of medicines.

All other items used at the psychiatric hospitals and units such as food, stationery, detergents and bedding are first requested for using requisition forms from the Stores department. At the stores department, the costs of the items issued are posted into a general ledger with corresponding entries at the expenditure side as they are used one after another till they area exhausted. All these are done manually and transferred into an excel sheet. Monthly, quarterly and annual financial reports are written.

4.3 Sources of Mental Health Funding

The sources of mental health funding are not different from that of the entire health sector. The study revealed that mental health funding and for that matter heath funds come from three main blocks. These are:

a. Government (GoG): Government funding is provided to the sector for four areas; Personal emoluments (salaries), Administration, Service and Capital projects.

Personal emoluments are paid directly from the government to individual staff accounts. The money for administration goes through the treasury for the mental health hospitals to apply for it. When it is approved, the money goes directly to the contractor for supplies. Funds for service go directly to the mental health hospitals. According to Dr. Dzadey, they are given more money for service than other hospitals because mental health hospitals do not generate funds as the others do. The capital projects or investments are also done directly by the government as and when there is the need. In the year 2008 for instance, Pantang Hospital had some allocation for capital projects to rehabilitate their out patient department (OPD) and six residential blocks.

b. Internally Generated Funds (IGF): IGF are mainly from proceeds from use of mortuary, VIP wards, OPD (for physical ailments), pharmacy and laboratory. Monies from pharmacy are restricted and cannot be used for anything else apart from purchase of psychotropic medicines in case of shortages at the central medical store. It must be noted that Pantang Hospital gets some IGF because they take care of other physical ailment. In Accra Psychiatric Hospital, Dr. Akwasi Osei remarked that the hospital “generates next to no funds.”

c. Donations/Donors: The Psychiatric Hospitals sometimes get in-kind donations. The study found out that unlike previously where donors used to give ear-marked funding to various health sectors, donors now give their funds to the health sector through a donor pool. This means that government decides with development partners in the health sector which areas of health deserve priority and which areas such monies from donors should be sent to. Since 2003, donors have been only multilateral institutions such as World Bank, Netherlands Embassy, Department for International Development (DFID) and Danish International Development Agency (DANIDA). Apart from BasicNeeds, no other NGOs have supported in the area of mental health. (See Matrix 2 & 3)

4.3.1 Out-of-Pockets Payments

Evidence from the study suggests that though out-of-pocket payment could be another source of mental health funding, it is highly informal. Through focus group discussions (FGD) with people with mental illness who access mental health services, the study found out that there are informal and unrecorded out-of-pockets payments by people with mental illness particularly in Ayawaso sub-metro who access mental health services from the Maamobi polyclinic.

Box

Psychiatric nurses take GH¢1.00 from us every month before we are given medications.
Sometimes if we do not have money to pay for the medications from the nurses, we go without medicines. They tell us that BasicNeeds has given us loans so we should be able to pay.
When I told them I don't have money to pay, the nurses told me that there are no envelopes to put my medicine inside so I should pay GH¢1.00 so that they get an envelopes for my medicine.
Sometimes when the nurses see that you are likely not to have money to pay for the medicines, they tell you there are no medicines. They usually direct us to a particular pharmacy shop and we feel that they send the medications there for sale. Often the one selling the medicine will ask, "I be master send you?"
If your hospital card is lost, you pay GH¢5.50 for a new one and this is too costly for us.

1

In Ashiedu-Keteke, Ablekuma, Okaikoi sub metros and Wa, people with mental illness explained that it is only when the psychiatric units do not have medicines that they are given prescription to purchase from chemical shops. In this regard, the Maamobi Poly clinic issue may be an isolated one worth investigating.

At Pantang Hospital, the situation is different. As a result of insufficient revenue generation, people with mental illness are required to pay a token towards the cost of medicine they receive. Each patient pays fifty Ghana pesewas (50p) for medicines received. According to the Pharmacist, they officially record this money received and keep it in an account called Drug Fund to purchase and replenish depleting stocks of psychotropic medicine when they do not get adequate supply from the central medical store. He also mentioned that they were able to use three years savings of such monies to purchase diazepam injection which was not at the central medical stores for about two years.

Apart from such payments by people with mental illness, (which place a financial burden on them), they also complained about the indirect costs to accessing mental health services relating to cost of travel and transport to the centre for the services.. Seventy percent (70%) of the respondents in the Focus Group Discussions said they would not be able to purchase their medicines if it happens that it is no longer free for they cannot meet both the cost of travel and paying for the medicines.

4.4 Mental Health Funding Allocation

4.4.1 Process and People/Departments Involved

Preparation of plans and budgets are annual rituals done by all units of the health sector. District plans and budgets are consolidated into a regional budget and forwarded to the Ministry of Health through the Ghana Health Service (GHS). For the psychiatric hospitals, they send their budgets directly to the Ministry of Health (MoH). Government usually gives guidelines by providing a form which contains information to be provided by the applicant for funding. This is then consolidated in a software and submitted to the Ministry of Finance and Economic Planning (MoFEP). It must be

noted however that government usually gives a ceiling budget for people to work within. The study found out that even if one prepares a budget based on the need that will only be considered if it does not exceed the ceiling given. “Theoretically we develop our budget but practically it doesn’t work as the national government has a ceiling they give no matter your budget or needs.” “It is not like prepare your budget and I will see how I can meet your needs. Instead they give us budget ceilings to work within which is always inadequate.”

The Ministry of Health organises a bi-annual planning session with all stakeholders in health to agree on an agenda or priority areas for prosecuting the health programme for the country. The health ministry then take charge of the consolidated budget, submits and defends it at the MoFEP. Key informants disclosed that the spot where actual health funding decisions, and for that matter mental heath funding decisions, take place is at the office of the Minister of Finance. It was noted that the parliamentary sub-committee on health are also involved in the approval process. Even though the health ministry does a lot of lobby for its prioritised areas/budgets, the most influential factors considered are government policy and agenda as well as ministerial policy. The Deputy Director of Policy Planning, Monitoring and Evaluation (PPME) of the GHS explained that for mental health to be prioritised, a lot of lobbying should be done before the planning meeting. Usually when a decision is made on a health component, more resources are allocated and this also means cutting down on other aspects of the health sector since the funds are not adequate. As a result of this, serious lobbying will have to take place before a decision is made on which aspect of health becomes a priority since no body expects a cut down in its budget.

Once the budget is approved by MoFEP, the MoH then allocates the budgets to the agencies under it. It must be noted however that funds are allocated by the MoH directly to the Psychiatric Hospitals. In addition, the release of funds to sub-metros or districts is based on the submission of memos by Sub-metro Directors or District Directors of Health Service to the office of the Metro Director in the case of the Accra Metropolitan Area and Regional Director of Health Service in that of the Upper West Region. With approval, cheques are prepared for the release of funds.

The MoH has no specific criteria for funding allocation to the various health sectors in the sub-metros or districts. However, there is a general direction that districts should not get less than 45% of the total health budget allocated to a particular region. How much goes to mental health is therefore a decision left to authorities concerned.

In Upper West Region, Dr. Nang-beifubah Alexis, the Regional Director of Health Services explained that the region has a criteria in the allocation of funds to the various districts in it. These are based on the population size, distance of the district from the regional capital, number of sub-districts and the burden of health diseases. Money is not directly allocated to mental health. It is given to clinical care so Community Psychiatric Nurses are expected to send in their budget to the clinical care department (hospital) for consideration.

Dr. Yabani, Metro Director of Health Service also indicated that his role in the allocation of mental health funding is principally to ensure that the lower levels of administration (sub-metros) are supported with vehicles to deliver community based mental health services. The Community Psychiatric Nurse, Maamobi Polyclinic confirmed this by saying, “We get our share of the health funds in the form of transport allowance for community based mental health services and stationery for the psychiatric unit.”

The Regional Coordinator in Charge of Community Psychiatry of the Upper West Region had this to say, “I do not know how funding is allocated to mental health in this clinic because for major activities, I always request for funding support from BasicNeeds. I have never sourced money from

the clinical health." He was however quick to add that the hospital gives him a budget imprest of GH¢50.00 every month. In addition, he has a requisition book which he requests twice a month for items like cotton, stationery, syringes and detergents. For the month of April 2009 for instance, the items he requested for were valued at GH¢128.80. With regards to medicines, he explained that they are taken from the regional medical stores through the Regional Director of Health.

Dr. Abebrese, the Medical Director in charge of Wa Regional Hospital explained that they do not have specific allocations to mental health and justified why the communal way of spending is the best for mental health care services. "As a hospital we run for all services including mental health. If we want to be programme oriented, then mental health will suffer because they do not generate any money but they are supported through our IGF from other health sectors. So the communal pool and consumption are a good advantage to mental health in that here, the strong supports the weak. The CPN make monthly requests for detergents and other things. He is also supported with a monthly imprest of GH¢50.00 just as every unit receives at this hospital."

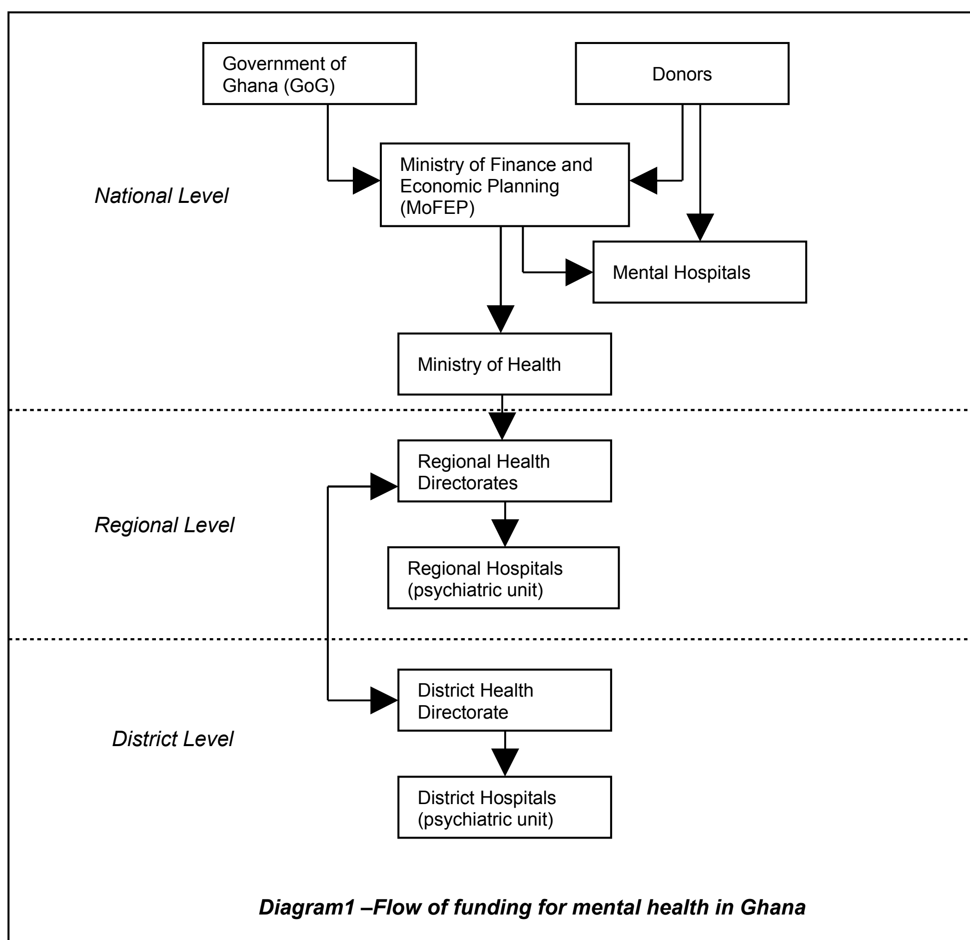

Diagram1 –Flow of funding for mental health in Ghana

4.4.2 Health Budget Allocation to Mental Health

The study looked at health budget allocation to mental health from 2003-2004 to 2007-2008 fiscal years. Table 1 shows a downward and upward trend in both the actual amounts and percentages of funds allocated to mental health. In 2003-2004, the percentage allocation to mental health was 2.97. This decreased to 1.89% in 2004-2005. Even though it rose up to 2.57% in 2005-2006, it was

still lower than that of 2003-2004. The decrease in years 2006-2007 was massive accounting for 1.63% which later rose to 3.87% in 2007-2008. At the Ministry of Finance, the Deputy Director of Budget, Mr. Frank Okyne explained that in 2006-2007 for instance, apart from budgetary limits for that year, more of the funds from the health sector were allocated to malaria.

Table 1: Health Budget Allocation to Mental Health

Year	Total Health Budget (Amount in Cedis)	Mental Health Budget	% Spent on MH
2007-2008	429,446,063.40	16,607,624.00	3.87
2006-2007	387,846,700.00	6,338,300	1.63
2005-2006	156,288,100.00	4,017,096.07	2.57
2004-2005	245,278,100.00	4,645,510.96	1.89
2003-2004	144,946,200.00	4,304,704.24	2.97

Comparing the cost of malaria in 2008 as reported in (GNA, 2009), the official news website of Ghana, malaria alone “cost Ghana $760 million”. This included procurement of medicines for the treatment of malaria, storage and transportation of drugs and man hours lost. This was reported to represent about 10% of the countries Gross Domestic Produce (GDP) for 2008. This confirms the priority given to other physical ailments like malaria over mental health.

In terms of multilateral institutions contribution to mental health, matrix 2 reveals a downward trend in the amount of money allocated to mental health. From 19% contribution of the total funds allocated to mental health in 2003-2004, this dropped to 18.7% in 2004-2005. This went further down to 7.6% in 2005-2006 and then to 7.2% in 2006-2007. Years 2007-2008 however showed a slightly upward increase of 1% bringing their contribution to mental health to 8.2%. As explained already in the process of allocation of funding to mental health, for mental health to get much support from the donor pool funds, it requires advocacy and negotiations by mental health professionals.

Overall, looking at funding allocations to mental health over a period of five years, it indicates government allocates an average of 2.20% of the total health budget on mental health. This is woefully inadequate considering the recommendation from the World Health Organisation (WHO) that countries should spend about 15% of their health budget on mental health. However, this could be more considering some support being given at the sub-metros/districts level for community mental health services such as transport and fuel for home visits and defaulter tracing.

Apart from BasicNeeds, the study found no other NGOs are supporting mental health except for few individuals, church groups and associations, and other philanthropic organisations (for example, ZONTA and LIONS Clubs) who occasionally donate either cash or gifts in kind directly to the psychiatric hospitals. BasicNeeds’ support to mental health includes psychiatrist expenses for outreach clinics, refurbishment of psychiatric units which are provided with recreational equipment people who come for treatment, provision of motor bikes and computers and their accessories and other office equipment. It also include paying of supplementary psychotropic medicines purchased, and training support to health workers and funding of horticulture projects at Pantang and Tamale for people under treatment.

4.4.3 Psychotropic Medicine

Purchase of psychotropic medicine is procured separately and does not come together with the mental health funding allocation. The Chief Pharmacist of the Accra Psychiatric Hospital, Mr. Coker explained that he collect information about the use of psychotropic medicines, collates the consumption rates and patterns in order to put together an annual budget for the procurement of medicines. He said he works closely with the Director for Procurement and Supplies of the Ministry of Health who receives the request of what is to be procured. The Director for Procurement and Supplies then meets the Minister of Health to justify the request made and it is forwarded to the Ministry of Finance and Economic Planning for approval and necessary action to be taken.

It was difficult to get information about the amount of money government has spent in the purchase of psychotropic medicines over a period of time. However, annual reports of Pantang Hospital indicate that in 2007-2008, they received psychotropic medicines from the central medical stores worth GH¢115,642.59. Comparing the value of medicines received from the Central Medical Stores (CMS) in 2007, there was a decrease of 82.12% in 2008. It is worthy of note that in 2007, Pantang had to purchase extra psychotropic medicine to the tune of GH¢10,642.58 and in 2008 an amount of GH¢21,102.75 on psychotropic medicines because the hospital experiences shortages. The Pharmacist at Pantang mentioned that it is because of such shortages that they levy a token fee on patient's medicines.

4.4.4 Funding Sources and Allocations for Public Mental Health

Drawing from GoG, multilateral institutions and IGF, the three psychiatric hospitals get their funding allocation directly from the Ministry of Health. From years 2003-2004 to 2007-2008, the Accra Psychiatric Hospital (APH), Pantang Hospital and Ankaful Hospital received an average of 47.69%, 30.17% and 22.14% respectively of the total mental health budget. Even though over the years, the amount received has been erratic, APH has continued to receive the biggest share of the funds allocated. Apart from it being the biggest psychiatric hospital in the country, they do not generate any IGF and that probably accounts for them getting the lion's share. (See Matrix 2)

Table 2: Funding Sources and Allocations to Public Mental Health

Year	MOH		APH		PANTANG		ANKAFUL		TOTAL
2003-2004	144,946,200.00	2.97	2,079,423.15	48.31	1,255,686.97	29.17	969,594.11	22.52	4,304,704.24
2004-2005	245,278,100.00	1.89	1,917,195.32	41.27	1,550,900.10	33.38	1,177,415.55	25.35	4,645,510.96
2005-2006	156,288,100.00	2.57	1,925,709.89	47.94	1,145,698.72	28.52	945,687.45	23.54	4,017,096.07
2006-2007	387,846,700.00	1.63	3,186,700.00	50.28	1,914,400.00	30.20	1,237,200.00	19.52	6,338,300.00
2007-2008	429,446,063.40	3.87	8,410,518.00	50.64	4,908,683.00	29.56	3,288,423.00	19.80	16,607,624.00
	1,363,805,163.40	2.63	**17,519,546.36**	48.78	**10,775,368.79**	30.00	**7,618,320.11**	21.21	**35,913,235.27**

4.5 Challenges in Mental Health Funding Allocation

Over 95% of respondents mentioned that resources for the entire health sector itself are not adequate and this affects funding allocation to mental health. This accounts for no funding allocation to mental health at the district and sub-metro levels even though Dr. Dzadey remarked that community psychiatry costs less than institutional care/treatment and that patients who stay with their relatives and visit the psychiatric unit regularly for treatment services get more stabilised than those who are confined in the mental hospitals. Records from Pantang Hospital indicate that

the hospital usually spends in excess of the allocation by between three to four percent. In the year 2007 for instance, they had total revenue of 755,742.53, whilst total expenditure was 783,658.25 giving an excess expenditure of about 3.7%.

In addition to the above challenge is the perception that mental illness does not kill as happens with malaria, maternal health and child-related illnesses. This does not make the health authorities consider mental illness as an area deserving priority once resources are limited. However Mr. Dan Osei noted this, “Though we do not have enough resources for the health sector, if even we had enough, I am wondering whether mental health will ever be a priority.” Dr. Dzadey also made this comment, “The general perception of mental illness also affects effective funding allocation. Is it a lost case or they can be treated and be beneficial to the society? People do not think about the loss of man hours for the patients and their families as they care for them. If people understood the effects of mental illness very well I believe that a small percentage of tax collection would be given to psychiatry.”

Lack of full time mental health professional lobbyists makes it difficult for them to lobby for more funds for their sector. Respondents noted that because of the long neglect of mental health, mental health professions need special effort more than the average to lobby for more funds. Mental health professionals are not many in the country and so they turn to focus on the delivery of mental health services instead of doing advocacy. Mr. Dan Osei was of the view that most of the times, mental health professionals talk only about the increasing numbers of people with mental illness which he believes will not ‘fetch them a pot of gold’. Instead he recommended that they should be able to tell politicians the economic loss to the state as a result of mental illness and this he thinks might help them gain some extra funds.

4.6 Sustainability of Mental Health Funding

The study revealed that though GoG funds and that from IGF was sustainable for the health sector in general, mental health funds from IGF was a big challenge since mental health services are free and as such the psychiatric hospitals and units do not generate any IGF. Moreover, even though GoG funds was noted to be sustainable, Dr. Akwasi Osei and Dr. Anna Dzadey (Ag. Chief Psychiatrist and Medical Director, Pantang) were of the view that GoG was erratic. At the time of this study in April 2009, Dr. Dzadey mentioned that she had not received any money from the government since the beginning of the year 2009. On 29th April 2009, Dr. Dzadey indicated that the hospital was left with just enough to feed in-patients for that day and their fate will be decided later on. Even though Dr. Dzadey acknowledged the fact that government gives the Psychiatric Hospitals more funds for service than the other health sectors because they do not generate IGF, the total funds allocated to them are still not able to meet their needs. She said the hospital usually spends in excess of the allocation given to them by between three to four percent (3-4%). In the year 2007 for instance, the hospital spent 783,658.25 as against total funds of 755,742.53 allocated to them giving an excess expenditure of approximately 3.7% (See matrix 4).

It is worthy of note that just a month (March 23 2009) before this study, the Daily Graphic had this headline, ‘Mental Health in Crisis’. It was reported that the Psychiatric Hospitals were at the verge of closing down as a result of no funds. Health budget allocation to mental health has not been consistent. It has been an upward and downward trend which does not augur well for mental health (See matrix 1).

5.0 KEY FINDINGS

- Low level of advocacy by mental health professionals results in low preference and prioritisation by funding authorities to mental health.
- Apart from the psychiatric hospitals, there is no specific budget line committed to mental health in the regions, metros, districts and sub-metros.
- Mental health funding occurs within the context of general health funding arrangements.
- Though government is the major funder to the health sector in general and mental health, this is usually supplemented by grants and donations from multilateral donors. However, mental health has not historically been a priority for NGOs.
- The psychiatric hospitals as well as the psychiatric units have information systems for recording mental health delivery services and utilization rates such as the number of patients accessing mental health services, dispensed psychotropic medications, stationery, detergents, etc.
- Sources of mental health funding are the same as the sources of funds for the entire health sector – government, IGF and Donations.
- Some patients pay for their medicines even though it is supposed to be free.
- Even though the mental health hospitals submit their yearly budgets, just like any of the health sectors, the funding allocated to them are based on ceilings given by MoFEP and not based on actual needs.
- The perceived importance of physical health as opposed to mental health as a priority couples with low level of advocacy and lobbying by mental health professionals partly accounts for the low attention and funding allocation to mental health.
- Health budget allocation to mental health has been erratic since 2003.
- It was difficult to get information about the amount of money government has spent in the purchase of psychotropic medicines over a period of time.
- Government allocates an average of 2.58% of the total health budget on mental health.

6.0 STUDY LIMITATION

This study has the following limitations that need to be taken into account when considering the analysis and its findings:

- This study is limited because analysis of qualitative responses involves a degree of subjectivity.

- This study was conducted in three out of four operational areas of BasicNeeds Ghana (Greater Accra, Northern and Upper West Regions). The findings therefore have been used to generalise for other regions in Ghana.

- There could also be a potential bias in the selection of key informants for this study.

7.0 DISCUSSION

7.1 Sources of Mental Health Funding

From the literature reviewed, the bulk of mental health funding just like the general health funding comes from the state coffers. This is true for Ghana as confirmed by the study. The psychiatric hospitals do not generate any funds and so is heavily dependent on government funds and donors.

7.2 Mental Health Funding Allocation

Unlike other Africa countries, Ghana has a specified mental health budget which is allocated to the three psychiatric hospitals. Unfortunately, the lower levels such as regions and districts are not allocated specific budgets for mental health. This is subsumed under the clinical care which sometimes is difficult to access.

Out of 89 countries understudies by Saxena, et al., 2001, 36% spent less than 1% of their total health budget on mental health. They explained that about 79% of Africa countries are in this group. This study, however, revealed that Ghana government allocates an average of 2.58% of the total health budget on mental health.

The literature reviewed indicated that allocation of funds is a function of how the government perceived certain disorders. This is the case in Ghana. Policy makers and authorities in health do not see mental health as an area deserving priority. It was evident from interviews of key informants that, more resources are allocated to other health sectors such as malaria and maternal and child health, including sexual and reproductive health as part of controlling high population growth, as well as other specific donor funded health programmes, such as guinea worm, tuberculosis, and trachoma because of the emphasis placed on mortality statistics. Because mental illness only disables and does not kill like malaria or HIV/AIDs, it does not receive the needed attention.

7.3 Barriers to Improving Mental Health Care

Apart from the challenge mentioned above about perceived importance of physical health to mental health, Knapp, et al., 2006 observed six barriers to improving mental health care which are information barrier, resource insufficiency, resource distribution, resource inappropriateness, resource inflexibility and resource timing.

In this study, inadequate resource for the entire health sector was said to be one of the reasons for limited resource allocation for mental health care. In addition, the resources are not fairly distributed as already explained amongst the health sectors. Even when mental health funds are allocated, one key informant revealed that most patients have stayed more than they should. To him, people should be discharged as soon as they feel better and then come regularly as out-patients for medications. This will reduce a lot of the cost incurred to feed and maintain them in the wards of the hospitals. Informal sources also revealed that patients are used as ‘ransom’ by the authorities to make money from food contracts. This remain allegations but credible to gauge against the pace at which community psychiatry is being promoted by those who must.

Moreover, the study found out that, government gives a ceiling to which every body is expected to work within. This is highly inflexible and does not make budgets for mental health reflect their needs.

Finally, government funds have been said to be erratic. For instance at the time of the study, Pantang Hospital, just like the Accra Psychiatric Hospital had not received their funds for 2009.

7.4 Impact of Mental Health Financing

Saxena mentioned that in most of developing countries, as a result of inadequate financing of mental health care, most people with mental disorders make out-of-pocket payments to receive mental health services. This is slightly similar to experiences of people with mental illness who receive mental health services in Ghana. The study found out that at Pantang Hospital, patients are made to pay a token fee for medications they receive which is deposited in a drug fund for purchase of psychotropic medicines when they are in short supply. In other areas, as a result of the irregular supply and shortage of psychotropic medicines, medications are prescribed for patients to purchase at chemical shops which place a heavy financial burden on them. Some are unable to purchase their medications leading to relapse. This means if fee paying is introduced with a caveat for the very poor (indigents) being exempted, perhaps the service can be improved.

This presupposes that, funds allocated to mental health needs to be seriously looked at and ways of generating IGF from the psychiatric hospitals and units should be considered if mental health funding is to be sustained. However, given the strong correlation between mental health problems and unemployment and low socioeconomic status, user charges for mental health services will be highly inequitable since those needing services will not be able to pay. Moreover, the chronic nature of many mental health problems potentially may mean that individuals will be subject to high lifetime costs of care.

8.0 RECOMMENDATIONS

Well targeted exemptions should be used in mental health care so that levies are charged on those who can afford the cost of medicines to reduce out-of-pocket payment for medicines.

Though it is well documented that funding for the health sector is generally inadequate, given the peculiar characteristics and vulnerability of people with mental illness, government should be committed to allocating funds to the lower levels of mental health care (regions/districts) and the mental hospitals according to identified psychiatric need.

There is the need for mental health professionals to monitor and analyse mental health problems and advocate to prove the effectiveness and cost-effectiveness of mental health care especially community based mental health care for adequate financing for mental health.

There is the need to build alliances/networks between the public and private sectors to advocate for improved mental health resource allocation and for the passage of the mental health bill which indicates that not less than eight percent of health budget will be allocated to mental health financing.

Mental health delivery services should as much as possible be effectively integrated at the primary care level which has been found to be cost effective as opposed to the institutionalised care so that the cost of care would be controlled.

9.0 CONCLUSION

This study has documented primary findings of mental health financing in Ghana and the challenges associated with financing of the mental health as a component of the overall health sector in the country. Overall, mental health professionals need to undertake effective lobbying by for improved prioritisation for the mental health sector. In addition, there is the need for civil societies and individuals interested in mental health to collaborate and ensure key decision-makers are influenced to adequately finance mental health and development services. This can be done if as a first step, pressure is put on the government to pass the mental health bill into law.

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MATRIX 1: HEALTH BUDGET ALLOCATION TO MENTAL HEALTH

Health Budget Allocation to Mental Health				
Year		**Total Health Budget**	**Mental Health Budget**	**% Spent on MH**
2007-2008	Amount in local Currency	429,446,063.40	16,607,624.00	3.87
	in US $	28,629,375.60	11,071,749.33	
2006-2007	Amount in local Currency	387,846,700.00	6,338,300	1.63
	in US $	258,564,466.67	4,225,533.33	
2005-2006	Amount in local Currency	156,288,100.00	4,017,096.07	2.57
	in US $	104,192,066.66	2,678,064.05	
2004-2005	Amount in local Currency	245,278,100.00	4,645,510.96	1.89
	in US $	163,518,733.33	3,097,007.31	
2003-2004	Amount in local Currency	144,946,200.00	4,304,704.24	2.97
	in US $	96,630,800.00	2,869,802.83	

MATRIX 2: FUNDING SOURCES AND ALLOCATIONS TO PUBLIC MENTAL HEALTH

Year	MOH		APH		PANTANG		ANKAFUL		TOTAL
2003-2004	144,946,200.00	2.97	2,079,423.15	48.31	1,255,686.97	29.17	969,594.11	22.52	4,304,704.24
2004-2005	245,278,100.00	1.89	1,917,195.32	41.27	1,550,900.10	33.38	1,177,415.55	25.35	4,645,510.96
2005-2006	156,288,100.00	2.57	1,925,709.89	47.94	1,145,698.72	28.52	945,687.45	23.54	4,017,096.07
2006-2007	387,846,700.00	1.63	3,186,700.00	50.28	1,914,400.00	30.20	1,237,200.00	19.52	6,338,300.00
2007-2008	429,446,063.40	3.87	8,410,518.00	50.64	4,908,683.00	29.56	3,288,423.00	19.80	16,607,624.00
	1,363,805,163.40	2.63	**17,519,546.36**	48.78	**10,775,368.79**	30.00	**7,618,320.11**	21.21	**35,913,235.27**

NB: Funding Sources are: GoG, World Bank, DANIDA and Netherlands Embassy.

MATRIX 3: NGO BREAKDOWN FOR MENTAL HEALTH ALLOCATIONS

NGO Breakdown for MH Allocations						
Year		**2007-2008**	**2006-2007**	**2005-2006**	**2004-2005**	**2003-2004**
		Total MH Allocation	**Total MH Allocation**	**Total MH Allocation**	**Total MH Allocation**	**Total MH Allocation**
BasicNeeds	**Amount in local Currency**	77,892.46	103,008.93	44,647.52	23,090.16	23,948.18
	in US $					
Multilateral Institutions	**Amount in local Currency**	3,155,448.56	481,710.80	305,299.30	353,058.82	817,893.81
	in US $	**2,103,632.37**	**321,140.53**	**203,532.87**	**235,372.55**	**545,262.54**
Other MH NGOs	**Amount in local Currency**					
	in US $					

MATRIX 4: CASE STUDY: ALLOCATION, EXPENDITURE, UTILIZATION (PANTANG HOSPITAL)

Case Study Health Clinic: Allocation, Expenditure, Utilization						
Year	**MH Service Categories**		**Funding Sources**	**Funding Allocated**	**Calculated Total Expenditures**	**Calculated Utilization Rate**
2007-2008	**In-patient MH treatment**	**Amount in local Currency**				**2,733**
		in US $				
	Feeding	**Amount in local Currency**	**GOG2/GOG3/DPF &IGF**	**109,500.00**		
		in US $				
	Detergents	**Amount in local Currency**	**GOG2/GOG3/DPF &IGF**	**219,733.00**		
		in US $		146,488		
	Stationery	**Amount in local Currency**	**GOG2/GOG3/DPF &IGF**	**54,115.00**		
		in US $		36076		
	Cleaning	**Amount in local Currency**	**GOG2/GOG3/DPF &IGF**	**97,056.46**		
		in US $		64,704		
	Laboratory Reagents	**Amount in local Currency**	**GOG2/GOG3/DPF &IGF**	**30,777.80**		
		in US $				
	Surgical and Dressing	**Amount in local Currency**	**GOG2/GOG3/DPF &IGF**	**21,872**		
		in US $		14,581		
	Maintenance (Plumbing, Electrical & Hospital Equipment	**Amount in local Currency**	**GOG2/GOG3/DPF &IGF**	**13,457.25**		
		in US $		8,971.50		
	Fumigation	**Amount in local Currency**	**GOG2/GOG3/DPF &IGF**	**655**		
		in US $		436.66		
	Out patient MH treatment	**Amount in local Currency**				
		in US $				
	Detergents	**Amount in local Currency**	**GOG2/GOG3/DPF**	**219,733.00**		**33,723**

			&IGF			
		in US $		146,488.66		
	Stationery	**Amount in local Currency**	**GOG2/GOG3/DPF &IGF**	**54,115.00**		
		in US $		36,076.66		
	Cleaning	**Amount in local Currency**	**GOG2/GOG3/DPF &IGF**	**16,496,390.50**		
		in US $		10,997,593.66		
	Laboratory Reagents	**Amount in local Currency**	**GOG2/GOG3/DPF &IGF**	**12,233**		
		in US $		8,155.00		
	Surgical and Dressing	**Amount in local Currency**	**GOG2/GOG3/DPF &IGF**	**13,768.00**		
		in US $		9,178.66		
			GOG2/GOG3/DPF &IGF	**3,364.25**		
	Maintenance (Plumbing, Electrical & Hospital Equipment			2,242.83		

NB: The hospital usually spends in excess of the allocation by between 3-4 per cent. In 2007 total revenue was 755,742.53, whilst total expenditure was 783,658.25 giving an excess expenditure of approximately 3.7%

APPENDIX 1: Topic Guide for Users/Carers Discussion

Introduction to the discussion
Thank you for agreeing to participate in this discussion
The purpose of the discussion group (state duration – 1 hour)
I will be asking you some questions to start our discussion, and you are free to contribute as you feel comfortable.
There are no right or wrong answers to the questions, we are interested in your opinions based on your experiences or the experiences of others you know.

Some ground rules about how the group will be conducted:
We ask you to respect each other's opinions, even when they are not the same as yours. Participation in the discussion is voluntary, so if you don't want to answer a particular question you don't have to, and you are fee to leave at any stage.
The discussion will work best if only one person speaks at a time.
Remind participants that the discussion will be recorded.

Obtain consent now

Questions:

1) What mental health services are you now receiving?

2) What are some of your challenges in accessing mental health treatment now?
   (Probe for financial issues)

3) Have you ever had to pay out-of-pocket for treatment? If so, for what specifically? Explain why.

Have you ever gone without treatment due to a financial burden? Explain.

APPENDIX 2: Topic Guide for Key Informant Interviews with Government Officials

Introduction to the interview
Thank you for agreeing to participate in this interview
The purpose of the interview (state duration – 1 hour)
I will be asking you some questions to start our discussion, and you are free to contribute as you feel comfortable. There are no right or wrong answers to the questions, we are interested in your opinions based on your experiences or the experiences of others you know.

Participation in the interview is voluntary, so if you don't want to answer a particular question you don't have to, and you are free to leave at any stage.
Remind participants that the discussion will be recorded.
Obtain consent now

1) Describe your role in MH funding allocation.

2) Who are the other people/departments involved in this process?

3) How are mental health services defined by the country? Which diagnoses are included under the umbrella of mental health services?

4) What are the current sources of mental health funding?

5) What records or information systems exist with data on MH public funding allocation?

6) Please explain the steps involved in MH funding allocation from the source to the recipient services.

7) How are mental health funding decisions made?
   (Probe for what sources are consulted to make these decisions)

8) What specific challenges do you encounter in this process?

9) What information is required to make well-informed MH budget decisions?

10) Do you think the current sources of MH funding are sustainable? Why or why not?

11) **If necessary, ask:** Do you know of any documents identifying sources and amounts of MH funding for previous years? If yes, which document(s)?

12) **If necessary, ask:** Do you know of any documents which identify NGO contributions to public MH funding? If yes, which document(s)?

13) **If necessary, ask:** Do you know of any documents that break down funding allocation amounts by specific MH services? If yes, which document(s)?

14) **If necessary, ask:** Do you know of any documents that identify utilization rates for these services? If yes, which document(s)?

APPENDIX 3: Topic Guide for Key Informant Interviews at Referral Hospitals, Districts, and PHCs

Introduction to the interview
Thank you for agreeing to participate in this interview
The purpose of the interview (state duration – 1 hour)
I will be asking you some questions to start our discussion, and you are free to contribute as you feel comfortable. There are no right or wrong answers to the questions, we are interested in your opinions based on your experiences or the experiences of others you know.

Participation in the interview is voluntary, so if you don't want to answer a particular question you don't have to, and you are free to leave at any stage.
Remind participants that the discussion will be recorded.
Obtain consent now

1) What mental health services are offered at your hospital/clinic?

2) How is mental health funding allocated in your hospital/clinic?

3) What records or information systems exist for recording MH service utilization information?

4) What records or information systems exist for hospital expenditures?

5) **If necessary, ask:** Do you have a method for recording each individual patient diagnosis? If so, how is the diagnosis determined and how is the record maintained?

6) **If necessary, ask:** Is usage for dispensed psychiatric medications recorded? If so, how is that information collected/recorded?

7) **If necessary, ask:** Is every patient visit recorded? If so, what information is collected and how is it recorded?

8) **If necessary, ask:** Is payroll information recorded for the hospital/clinic? Is that information accessible to us?

9) Do you have adequate resources for providing mental health services? If not, which areas are lacking?

APPENDIX 4: Key Informants Interviewed

- Deputy Director, Policy Planning, monitoring and evaluation o f the Ghana Health Service (Mr. Dan Osei)
- Medical Director, Pantang Hospital (Dr. Anna Dzadey)
- Chief Pharmacist, Accra Psychiatric Hospital (Chief Coker Asaam)
- Pantang Pharmacist (Mr. Samuel Amponsah Botchway)
- Accra Metropolitan Director of Health Services (Dr. John B.K Yabani)
- Upper West Regional Director of Health Services (Dr. Alexis Nang-beifubah)
- Upper West regional Accountant of Health (Mr. Saeed Abdulai)
- Community Psychiatric Nurses (2 from the Maamobi Polyclinic, Accra and 1 from Wa Regional Hospital) Winfred Darko, Emmanuel Asare &Lawrence N. Walter respectively)
- Medical Director of the Wa Regional Hospital (Dr. Abebrese)
- Acting Chief Psychiatrist (He also doubles as the Medical Director of the Accra Psychiatric Hospital (Dr. Akwasi Osei)
- Director of Procurement and Supplies, Ghana Health Service (Mr. Samuel Boateng)

APPENDIX D: Informed Consent Form

A research project being undertaken by BasicNeeds.

Key information to be communicated to each participant BEFORE commencing the Focus Group Discussion or Interview.

Information	**Understood?**
We are looking at mental health financing	
This group discussion/interview will take 1 hour of your time	
Everything said will be confidential. The discussion may be recorded, but this will be protected from others. Please keep what is discussed in this group to yourself.	
You do not have to be a part of this discussion. You may leave when you choose. Your choices will not affect your relationship with us.	

Will you participate? **YES NO**

I have communicated the above information to ____________ and he/she has agreed to be involved in the Focus Group Discussion/Interview.

Signature: ____________________________ Date: ____/____/____

Witness: _____________________________ Date: ____/____/____

Before we begin, do you have any questions you would like to ask?