

Why Can't Canada Spend More on Mental Health?

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Abstract

The World Health Organization (WHO) notes that mental illness accounts for 13% of the world's disease burden, yet most countries under invest despite the social and economic costs of mental illness. It has been suggested that this lack of investment may be a result of stigma. A number of high income countries invest 10% or more in their mental health services. Although Canada is a high income country, its mental health spending is 7.2% according to the WHO Mental Health Atlas. This article will review the factors influencing Canada and its provinces' under investment in mental health, compare its performance with other countries and make the case on why and how this could change.

Keywords

Funding; Mental Health Policy; Investment

1. Introduction

While mental illness accounts for 13% of the world's disease burden [1], most countries under invest despite the social and economic costs of mental illness. A number of high income countries invest 10% or more in their mental health services. Although Canada is a high income country, its mental health spending is 7.2% according to the WHO Mental Health Atlas [2]. This article will review the factors influencing Canada and its provinces' under investment in mental health, compare its performance with other countries and make the case on why and how this could change. A literature review of issues related to mental health spending in Canada, the UK, Australia and New Zealand was conducted. Where available, new investments in mental health services up to 2011 were noted and the amounts were converted into Canadian dollars using 2011 exchange rates so that per capita investments could be calculated and compared. Only the UK shows the effects of inflation over the period of

new investment, so absolute rather than relative investments are analyzed for comparative purposes.

2. The Investment Gap

The WHO observes that “there is a substantial gap between the burden caused by mental disorders and the resources available to treat and prevent them” and notes that the problem is more acute in low and middle income countries where 80% of people in need do not receive the treatment they need. [3]. The Mental Health Commission of Canada notes a similar problem in Canada. Only one in three adults and as few as one in four children receive mental health treatment and support when needed. [4] A few high income countries invest 10% or more of their health budgets on mental health services such as the UK and Sweden [5] but even this amount appears to be insufficient.

The Royal College of Psychiatrists in the UK reports that mental illness is the single largest cost to the NHS, taking up 10.8% of annual spending [6]. They note: “Mental illness is the largest single source of burden of disease in the UK. No other health condition matches mental illness in the combined extent of prevalence, persistence and breadth of impact. Mental illness is consistently associated with deprivation, low income, unemployment, poor education, poorer physical health and increased risk behavior”. They call for significant investment and argue the investment will reduce associated personal and social costs while achieving significant economic savings [7].

Paradoxically this call for investment was written following years of investment which saw real spending increase by over 50% [8]. Heather Stuart and colleagues argue that the lack of sufficient investment may reflect “a process of structural stigmatization” [9] where investments in mental health are deemed less worthy due to the stigma associated with mental illness.

A number of countries have developed or retooled their mental health plans over the past 20 years and have articulated a need to shift funding from psychiatric institutions to community services and develop strategies to improve integration with primary care. The WHO notes that among countries with mental health plans, 80% have timelines for implementation and 55% have provided funding for the implementation of the plan [10].

New Zealand, the UK and Australia had mental health plans that drove investment over a period of years. New Zealand saw their mental health expenditures rise from \$270 million in 1993 to \$1.2 billion by 2011 by which time 76% of their spending was on community mental health services and the mental health share of health spending was 9.5% [11].

As noted earlier, the UK increased their investment in mental health services by over 50% between 2002/3 and 2011/12 and focused their new investments on community based services such as assertive outreach, crisis resolution, home treatment and early intervention in psychosis, as well as increasing access to psychological therapies. For example over a nine year period spending on crisis services increased by 171% and spending on psychological therapies increased by 152%. At the same time, spending on secure services increased by 162% [12].

The National Mental Health Commission of Australia noted that Australia’s mental health spending accounted for 6.5% of national expenditures on health while mental illness accounts for 14% of disease burden. Further the National Mental Health Commission noted that the spending was oriented toward acute care rather than prevention and early intervention [13]. In budget 2011/12 the national government committed to invest a further \$2.2 billion to improve mental health services over 5 years which also included \$201 million for partnership funding with the states and increased funding for supportive housing. The budget noted that this spending would complement “the government’s commitment to spending more than \$5 billion to address homelessness including build thousands of new homes for people who are homeless and increasing support services” [14].

Despite this commitment to invest, the Chair of the Mental Health Commission noted the case for investments in his 2013 Report Card saying: “Improving mental health is an invest-to-save issue. Tackling the causes rather than the symptoms; preventing mental illness and suicide in the first place; promoting good mental health for everyone; and timely support when things start to get tough, is the best economic and social renewal strategy that we can invest in. Our current system is not designed with the needs of people and families at its core. These needs are wider than health services—they are about supporting recovery and leading a contributing life” [15].

3. Canada’s Performance

Australia, New Zealand and the UK all have had mental health plans, service targets and targeted investments

since the late 1990s. Canada did not have a national mental health plan until 2012. While there is federal /provincial cost sharing for health services, health care is a provincial responsibility under the Canadian constitution. Over the past twenty years all provinces developed mental health plans, but while they set out policy direction, they lacked targets and funding commitments. As a result while there has been increased funding for health care over the past 10 years, very little of the increase was allocated to mental health.

The province of Ontario is a case in point (Figure 1). In 1979, before the first mental health reform was published, the mental health share of health spending was 11.3% [16]. In 1988 Ontario published the Graham Report: Building Community Support for People which proposed building a community focused mental health system and set the stage for subsequent reform documents [17]. An analysis of spending by the author at the time showed that the mental health share of spending had declined to less than 10% by 1985. A subsequent analysis four years after the publication of the report showed that mental health spending continued to decline to 8.2% despite government endorsement of the Graham Report and a new mental health reform policy which proposed targets increasing community mental health spending to 60% of the mental health budget by 2003 [18].

In terms of absolute dollars there has been an increased investment in community mental health spending. Prior to the Graham Report the Ontario government was spending \$45 million on community mental health services. Over 25 years this has grown to over \$860 million and the share of community mental health spending relative to overall health spending has grown to 1.31% from 0.45%. [19]. However an analysis of mental health spending by Canadian provincial governments shows that Ontario allocates slightly less of its health spending to mental health than the 7.2% national average [20]. Per capita spending on community mental health supports this finding. Ontario spends \$51.19 on community mental health while the weighted Canadian average is \$53.00 [21].

Between 2004 and 2011 the government of Ontario invested \$220 million in the expansion of community mental health services. Similar to the UK, these investments were targeted into priority areas such as early psychosis intervention, assertive community treatment, community mental health and justice services, supportive housing and crisis intervention. While these investments were welcomed, they represented a small fraction of increased health spending. Ontario invested an additional \$18.5 billion in health care during the same period. This works out to a per capita investment of \$1361 (Figure 2) in health care compared to \$16.45 for mental health [22].

Unlike Australia, the Canadian federal government has not earmarked federal transfer payments to the provinces to improve mental health, but has increased transfer payments since 2004 for health care. Between 2005

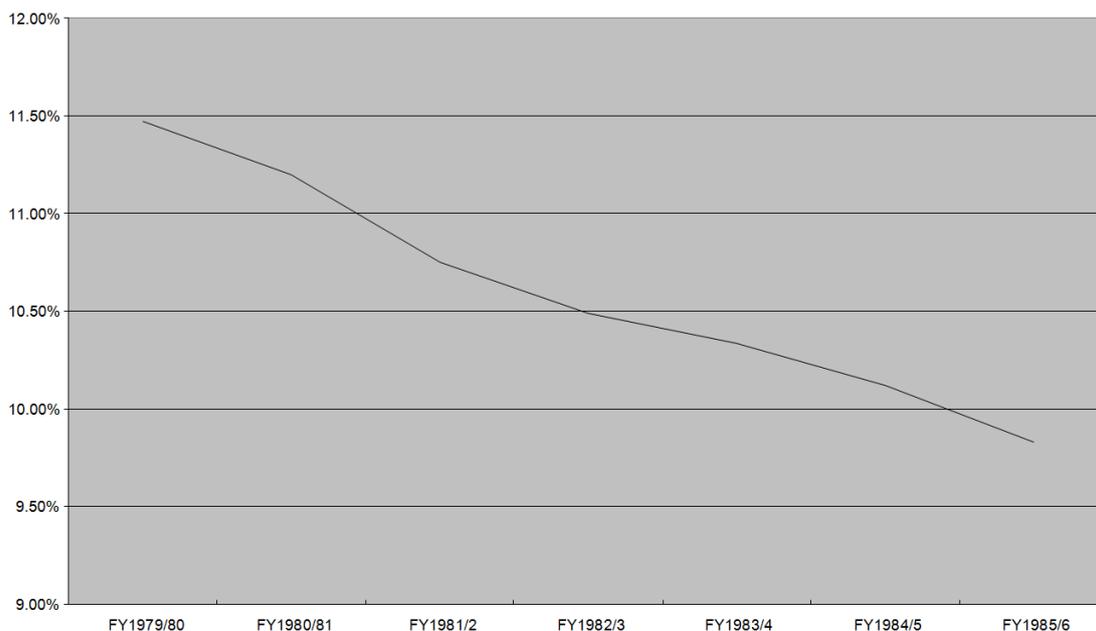


Figure 1. Mental health spending percentage of Ontario health spending.

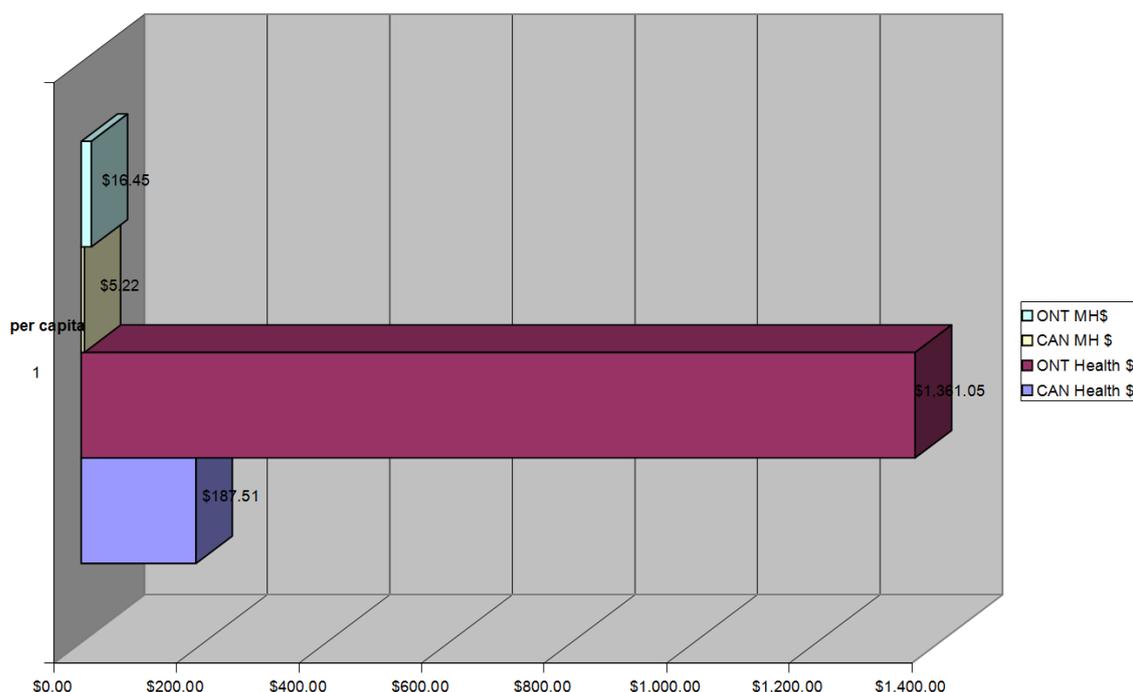


Figure 2. Per capita investments on health, mental health: Ontario compared with Canada.

and 2011 federal fiscal transfers for health care increased by \$6.6 billion. Ontario's share of transfers increased by \$2.9 billion, but as indicated previously very little of this amount, accrued to new investments in mental health services [23].

The Canadian government has invested in the Mental Health Commission of Canada to catalyze action on mental health since 2007. In 2006 the Senate Committee on Social Affairs published *Out of the Shadows At Last* which recommended the establishment of a mental health commission to develop a national mental health strategy and a national mental health transition fund of \$5.3 billion which was to run for 10 years and help provinces and territories develop community focused mental health systems and more supportive housing [24].

Funding of \$530 million per year would have been transferred to the provinces had the fund been established. It would have represented a small incremental cost of 0.29% the \$182 billion spent annually on health care in Canada but facilitated the establishment of service targets and increased investments in mental health services. While this did not occur, the government of Canada did invest \$110 million in a Housing First service development and research project over 5 years, At Home/Chez Soi which has provided public policy evidence of leading practices to reduce homelessness among people living with mental illness. The federal government has also funded the Mental Health Commission for a 10 year period with an annual budget of \$15 million per year. Taken together these new investments in mental health represent and increase in per capita mental health spending of \$5.22, compared to \$187.51 invested in health care generally.

While Canada and Ontario have made new investments in mental health care recently, their per capita investments pale in comparison with the UK, Australia and New Zealand (Figure 3). Using 2011 Canadian dollar exchange rates, the UK investment was \$62.22, Australia's was \$98.13 and New Zealand's was \$198.93.

However, given the current economic climate, it appears that the days of increasing mental health investments may be ending. In 2011/12 UK investment in priority areas actually fell [25] and the recently published New Zealand mental health plan notes that the government faces significant financial constraint, very limited new funding and the focus will be on increasing productivity and using resources more effectively [26].

In 2013 the Mental Health Commission of Canada released *Making the Case for Investing in Mental Health* [27] in Canada. The report echoes themes from the WHO, UK, New Zealand and Australia in terms of the burden of mental illness, direct and indirect costs to the Canadian economy, and uses Canadian data to buttress the call for government action. The MHC notes that the cost to the Canadian economy is \$50 billion per year and the cumulative cost to the economy over the next 30 years will be \$2.5 trillion.

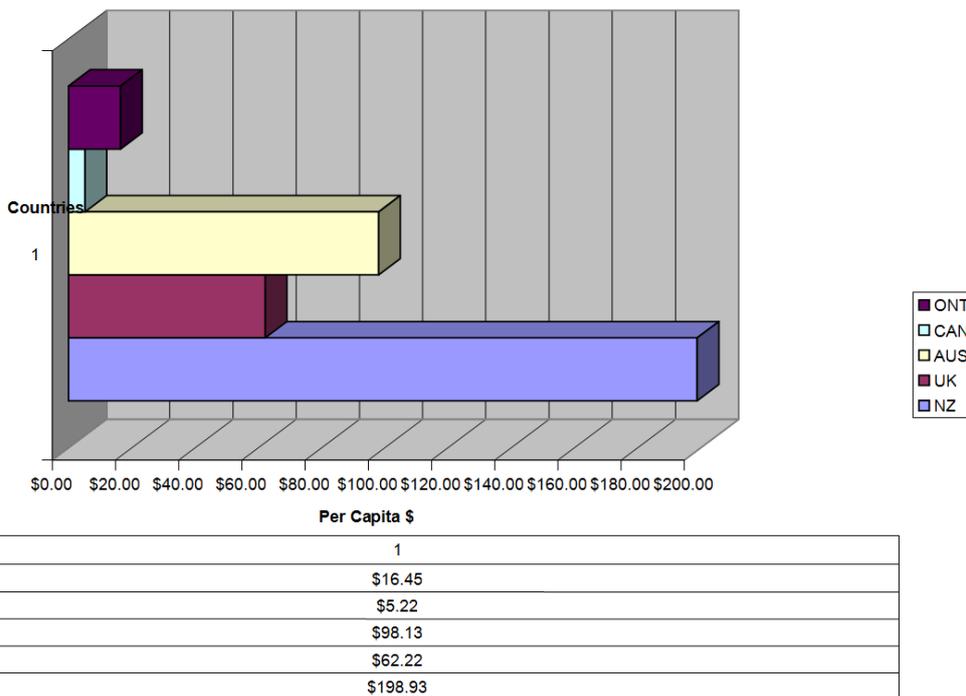


Figure 3. Comparative per capita new investments in mental health: Ontario compared with Canada, Australia, UK, NZ.

It also notes the population impact- noting that more than 6.7 million Canadians out of a total population of 37 million are living with mental illness, compared to 2.2 million people with type 2 diabetes. By the time people reach 40 years of age—50% of the Canadian population will have had or will have a mental illness. The report also cites evidence of effective interventions and notes that it would be possible to reduce incidence and relapse which would save health care systems money going forward.

The previous year Ontario’s Institute for Clinical Evaluative Services published *Opening Eyes, Opening Minds* which shows “the burden of mental health and addictions is more than 1.5 times of all cancers and more than seven times that of all infectious diseases.” ICES note that while effective treatments exist, only a small portion of affected individuals receives them [28].

4. Conclusions: Prospects for Change

We now have international and national evidence of disease burden, and evidence about effective treatment and community supports, as well as compelling evidence in this country and others about lack of access to mental health services. Will this be enough?

Possibly. Canada’s new mental health strategy does provide a useful blueprint to improve access to community services and supports, as well as better integration with primary care. Corporate Canada is also taking an increased interest in mental health and this may contribute to the creation of political will to make mental health a priority.

The mental health strategy deals head on with one of the shibboleths of mental health system failure—deinstitutionalization. It argues that deinstitutionalization is the right policy. The failure is the lack of investment in community services [29]. In Ontario, most of the beds were closed between 1959 and 1969. By 1979, the mental health share of health spending was 11.3%. As shown earlier, this has now declined to 7%, which suggests that priority investments in other areas of health care contributed to the loss in share of spending, rather than the savings due to bed closures. The MHC mental health strategy proposes increasing the mental health share of health spending to 9% across the country and increasing social spending by 2% to ensure investments in housing, employment and income support. These are not unreasonable targets. For example, increasing spending in Ontario by \$160 million per year would add 0.3% to health spending increases and offset costs in hospitalization, hostels and jails.

The Parliamentary Budget Officer indicates in his recent report that the Canadian government will have fiscal room to make investments in priority areas after the budget is balanced in 2015 [30]. Let's hope that helping the provinces reform their mental health systems and improve access to care is one of them.

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