

EDITORIAL**THE NEED FOR A RADICAL TRANSFORMATION OF THE HEALTHCARE SYSTEM IN ETHIOPIA: EXAMPLES FROM MENTAL HEALTH RESEARCH**Abebaw Fekadu, MD, PhD, MRCPsych^{1*}, Atalay Alem, MD, PhD²

We ignore mental disorders at our own peril. Six of the leading 20 causes of the global disease burden are mental and behavioural disorders, with depression topping the list as the second leading cause (1). In Ethiopia, extensive knowledge about mental disorders and their impact has been gained from scientific observations since the establishment of modern mental healthcare in the country. These studies have involved diverse population groups: women, children and adults; general populations, social isolates, displaced people and the homeless. Overall, four generations of studies may be distinguished. The first-generation studies were conducted primarily in health facilities and involved interviews by psychiatrists. The second-generation studies were mainly population based and used screening tools administered by lay interviewers.

The third-generation studies constituted a major methodological advance and employed structured diagnostic interviews administered by clinicians. The latter studies were particularly relevant for the understanding of psychotic disorders. Through these three generations of studies it was possible to make a strong public health case for mental disorders: that mental disorders are common, serious, but treatable. The Butajira project on severe mental disorders (schizophrenia, bipolar disorder and severe depression) is arguably the most important study in relation to disease conditions, scope and impact (2). One of the notable outputs of this study was the demonstration that people with schizophrenia, depression and bipolar disorder die about three decades prematurely compared to the rest of the population (3).

The fourth-generation studies involved clinical trials, complex interventions and neurobiological studies. The complex intervention studies attempted to model innovative, safe and scalable care approaches to ensure quality mental healthcare in primary care settings. Two studies that may be considered a fourth-generation studies are published in the current issue of the Ethiopian Medical Journal (4,5).

Understanding and dealing competently with multi-morbidity is the linchpin of a modern health service anywhere in the world. Depression has emerged as an important co-morbid condition with both communicable and non-communicable diseases in developed as well as developing countries. For example, a study among patients with tuberculosis in Ethiopia has demonstrated not only strong co-morbidity between depression and tuberculosis but very serious consequences arising from such comorbidity (6). Patients with tuberculosis and co-morbid depression at entry to care were prospectively at a significantly increased risk for premature mortality, disability, poorer quality of life and treatment default. The high comorbidity between hypertension and depressive symptoms reported by Abraham T., et al. and Fekadu A. and Alem A, in this issue (4,5), while not surprising, should raise concerns.

Non-communicable diseases (NCDs) have become major public health problems in Ethiopia. According to the recent report by the Ethiopia NCDI Commission, 43.5% of mortality in Ethiopia was related to NCDs. Hypertension is of particular concern. It has high prevalence in Ethiopia, and is also an important risk factor for other NCDs (7). Alarmed by the high prevalence, some have referred to hypertension as the “silent epidemic” (8). Admitted that the high prevalence of depression in people with hypertension may in part be due to the use of a symptom checklist, the article rightly highlights the challenges of the modern health system -detecting co-morbidity and providing adequate quality care when detected. Nothing short of a drastic transformation of the healthcare system of Ethiopia is required if it is to be fit for the 21st century health needs of the country.

The second paper in this issue (5) highlights the gaps in the healthcare system in relation to caregiver burden

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among carers of people with psychosis. Informal caregivers are the backbone of healthcare in developing countries. While most caregiving will arise from other NCDs, severe mental illnesses can make caring more difficult. The lack of social care and the virtual absence of biomedical care in most parts of the country makes caring more challenging. Using a comprehensive assessment tool that evaluated a range of experiences linked to caring, the study showed a high level of burden related to a range of care experiences. Despite the high level of burden of care, caregivers rarely wanted ‘out’. Their utmost concern was the wellbeing of the patient. This is more inspiring considering the virtual absence of social care programmes, the extreme inadequacy of biomedical care and the little support from informal providers, such as Non-Governmental, religious and community organisations (9). While this is a testimony to the fact that ‘unsung’ heroes live almost in every household, this status quo is unacceptable. What is the implication of these two studies for healthcare in Ethiopia? The studies are a window into the need for a radical transformation of the healthcare system. First, the acute care model, that is pervasive in the current health system is not fit for purpose.

Multimorbidity, co-occurrence of two or more chronic conditions, is the reality of modern healthcare. For example, at least one in four people in the United Kingdom and United States of America have multimorbidity, with two-thirds of those aged 65 and above having multimorbidity (10.11). Adopting the chronic care model, instead of the prevailing acute care model, would help in addressing key comorbidities, such as depression, that affect quality of life and disease outcomes adversely. The personalised and continuous engagement in the chronic care model would also increase the possibilities for detection of co-morbid depression. The recent increase in the number of medical graduates, combined with the requirement for continuous professional development, offer a platform for substantive quality improvement.

Innovations to engage and support informal caregivers is also an urgent priority. If not for the sake of the caregivers, the changing socio-demographics, economics and culture demand changing the way healthcare systems extend support to caregivers. A chronic care model requires a ‘community’ approach to healthcare. This means empowering not only the patients but also the caregivers. The ‘respectful’ and ‘compassionate’ care agenda that engages the patient and carer is essential. This also calls for engaging the rich community resources that are currently little appreciated and deployed. It is also noteworthy that highly infectious diseases, such as the COVID-19 and tuberculosis, also demand a new approach to caregiver engagement. A serious commitment to improving the quality of care requires a serious commitment to transforming the current care model drastically.

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