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## COUNTRY PROFILE

# Mental health in Argentina

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**A**rgentina, the second largest country in South America, is a federation of 23 provinces and its capital, the autonomous city of Buenos Aires. Its population is a little over 40 million, 50% of whom reside in its five largest metropolitan areas. The rural areas are extensively underpopulated. The city of Buenos Aires and its suburbs contain 15.5 million inhabitants, making it one of the largest urban areas in the world.

Although Argentina belongs to the high- to middle-income countries according to the World Bank, its socioeconomic inequalities are extensive. Sharp contrasts exist between the urban and rural areas. Between 29 and 33% of its population live below the poverty line.

During the 20th century, the country saw several military coups and administrations in between periods of precarious democratic government. Military regimes, repression of the opposition, hyperinflation and several collapses of the economy took a heavy toll on the mental health field. Importantly, more than one generation of professionals and academics were effectively exiled abroad, damaging the country's scientific system and research capacities. Argentina is currently experiencing its longest unbroken period of democracy in its history, and the most recent signs indicate a trend for academics and professionals to return, in response to improving conditions and government incentives, but the consequences of the earlier turbulent history cannot be ignored.

Argentina as yet lacks a national system for data collection for mental health. Each province has its own system. Data pertain mainly to the public system, and exclude the substantial private sector, making the information incomplete.

## Policy and legislation

The National Mental Health Authority provides advice to government on policy and mental health legislation. However, it is not involved in planning, monitoring or evaluating the quality of services. These domains are under the independent responsibility of each province.

In 2010, the National Parliament approved the Law for Mental Health Services, which covered service planning and policies, mental health in primary care, as well as monitoring of compulsory admissions to hospitals. It is not yet clear how this change will affect existing services.

A survey by the World Health Organization (WHO) on the state of mental health services in Argentina gathered much useful information (some reported below), although it covered only ten provinces. Nine of these have explicit mental health policies drafted. A Federal Plan for Mental Health was drafted in January 2008, but is still vague and not widely supported by all the provincial authorities.

The budget for mental health is below WHO recommended levels. Allocations vary among the provinces, from 0.5 to 5.0%. Nationally, 68% of the mental health budget goes to psychiatric hospitals, leaving community services underresourced.

Six provinces have an official list of essential medications. However, the lack of clinical guidelines leaves the availability of medical treatment potentially subject to market mechanisms, with pharmaceutical companies exerting pressure for the approval of medication that is not necessarily supported by clinical evidence.

## Service delivery

Health services are delivered by several systems that coexist in a structure that is subject to little formal regulation, being essentially a free market health economy. The federal state bears no responsibility for health cover for the population, which is instead devolved to provincial control. Each province has a public health sector that gives free cover. Its resources are limited.

The national social security system is financed by contributions from employers and workers. However, people who are unemployed are not covered by this. Private insurance plans, taken out independently by individuals, cover more than 12% of the population, mainly in urban areas. Pensioners and people with a disability receive cover provided by the

federal state, financed in a similar way to the social security contributions system, but through contributions from the state and state pensions. Disability allowances are paid by this federal system.

Local councils and provincial governments provide the large psychiatric hospitals. These are poorly resourced and most of the workforce are underpaid or work voluntarily. The four largest hospitals in Buenos Aires, with a total of 2221 beds, have been threatened with closure, but no plans have been made for patients' relocation. Despite developments in social assistance provision in recent years (e.g. the introduction of the 'Head of Household Programme' in 2002), national housing and welfare policies in Argentina remain of a less established and comprehensive nature than those that exist in many European countries, including the UK.

Argentina has a total of 20945 general psychiatric ward beds (10864 public sector and 10081 private). The number of private beds has increased notably since 2001, unlike the number in the public system. There are 186 private hospitals and 45 private institutions for people with addiction problems. The majority of private facilities are in the main cities.

Community services also exist. There are 533 out-patient mental health facilities available in the 10 provinces surveyed, of which 28 are for children and adolescents. There are 65 day hospitals in the 10 provinces, of which only 4 are for children and adolescents. The province of Buenos Aires has 60 units, with a total of 244 short-term beds. Several provinces have mental health services without in-patient beds. This difference illustrates the geographical inequalities that exist, with large urban areas containing the highest concentration of resources.

In summary, treatment within the public sector still relies on a model based on the psychiatric hospital, at least for severe mental disorders. Three provinces (Neuquén, Rio Negro and San Luis) conducted a successful process of deinstitutionalisation during the 1990s. However, their combined populations constitute just 4.03% of the total national population. In these areas, following deinstitutionalisation, the private sector advanced, opening facilities for those patients who needed admission. This puts the model itself into question in terms of public health considerations.

## Psychiatric training

The main system for postgraduate training is through the medical residence programme, which lasts 3–4 years for those taking it full time. There are about 450 vacancies nationwide. Another system is through part-time work in an approved service, but it is not paid and so has more vacancies than the former. Further routes into the specialty are university postgraduate training, which lasts 3 years, and the training organised by the Association of Argentinean Psychiatrists. The latter has also run a programme for recertification since the 1990s. Although it is not mandatory, it has been very successful, drawing a wide attendance to its annual meeting, and also generating a training network for the more distant provinces and rural areas.

There are no examinations to qualify for the Certificate of Specialist in Psychiatry. The Ministry of Health awards this certificate to professionals who have worked a total of 5 years in the specialty (either part time or full time).

Mental health training in primary care is poor. Some programmes for physicians receive a strong input from the pharmaceutical industry. The Health Ministry runs almost no regular professional training programmes for physicians and nurses working in primary healthcare. A training programme for over 8000 family and community physicians, implemented in 2008 by the Ministry of Health, has no mental health content. The first author of this article did deliver training for family doctors at the 2010 National Psychiatric Congress, based on a 'stepped care' model for the detection and treatment of mental disorder in primary care, but much still needs to be done in this field.

## Workforce issues

There are 13.25 psychiatrists per 100000 inhabitants. They are located mainly in Buenos Aires and the other urban centres. Prominent inequalities still exist with respect to the rural areas, many of them having no access to specialist services, or indeed mental health professionals at all.

Data for Argentina suggest a lack of nurses when compared with doctors, with a ratio of about one nurse to ten doctors (in all medical specialties). In the ten provinces surveyed by the WHO (2011) there were 12.91 psychiatric nurses per 100000 inhabitants. Data for other provinces are still lacking or unreliable, due to the exclusion of the private sector in the data. It is also worth mentioning that the operational definition of a 'nurse' varies from province to province. The profession of community psychiatric nurse does not exist as in the UK. There is a surplus of psychologists (172 per 100000 inhabitants, compared with 9 in the UK and 31.1 in the USA, for example). There are 11 social workers per 100000 inhabitants, but they do not usually form a part of mental health teams. Child and adolescent psychiatry is still understaffed, with only 295 registered specialists in this area.

It should be noted, however, that there can be substantial differences across countries in the training and practice of the above categories of professional. An example is how the roles undertaken by Argentine psychologists are far wider than those undertaken by British clinical psychologists. In Argentina 'clinical psychologist' is a graduate post that requires no mandatory clinical training before registration, while in the UK the job is highly regulated and specialised, requiring doctoral training that includes both research and supervised clinical practice. In Argentina psychologists often do work that would be carried out by a variety of other professions in the UK, such as specialist nurses and social workers, or generic mental health workers. Moreover, many of the specialist skills offered by a clinical psychologist in the UK do not form part of mandatory training in Argentina (e.g. psychometric evaluation). It is important to observe that, while the data suggest an excess of specialised psychological input, it is more likely that psychoanalytic input is over-represented and other (evidence-based) aspects of such input are lacking.

It remains unclear whether, in Argentina, psychologists are filling some of the gaps in service provision created by the shortage of professionals such as specialist nurses and social workers. More research is needed to obtain a better understanding of the skills mix on offer.

## Main research areas

There has been insufficient epidemiological research. This explains the lack of reliable information that would be expected of current evidence-based mental health approaches. Funding for medical research through the National Council for Scientific and Technical Investigations is almost nonexistent. Under these conditions, research in the biomedical areas is restricted to the pharmaceutical industry.

In contrast, within Buenos Aires a psychoanalytical tradition, dating back to the 1940s, has developed. It is at present considered the 'most psychoanalysed city' in the world. Two psychoanalytical societies are affiliated with the International Psychoanalytical Association. Psychoanalysis has exerted a powerful influence on the mental health system, and still constitutes a very important part of the psychiatric curriculum.

## Human rights

There are several laws that regulate compulsory admission to hospital, the status of people under guardianship (including property) and periodical review of those patients compulsorily admitted. Again, these regulations vary across the provinces.

Progress has been made in relation to the traumatic sequelae of the so-called 'dirty war' (1976–83). Mental health professionals have been organised to assist with the restitution of children abducted by the military. Several non-governmental organisations are widely involved with the subject of human rights and the prominent socioeconomic inequalities in health. There is still much work to be done in this area, particularly in relation to housing. With the presence of a stable democratic government, it is very much hoped that the necessary changes will soon be implemented.

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## COUNTRY PROFILE

# Mental health in Botswana

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**B**otswana is a landlocked country located in southern Africa. More than two-thirds of it (70%) is covered by the Kalahari Desert, known locally as the Kgalagadi. The majority (82%) of the nearly 2 million population live in the eastern part, along the railway line from Lobatse in the south-east to Francistown in the north-east, and the rest in the central part, including the Okavango River delta.

Botswana is about the size of Kenya, France or the State of Texas and is thinly populated. The surface area is 581 730 km<sup>2</sup> (363 581 square miles). This poses a challenge in the provision of health services in general and psychiatric services in particular. About 45% of the population is under

15 years of age. Over 50% are settled in urban areas. The four main centres are: the capital city, Gaborone (population 250 000), in the south-east; the second city, Francistown (105 000), in the north; Lobatse (60 000); and Selebi-Phikwe (50 000).

It is a multiparty democracy that became independent from Britain in 1966. It has achieved the status of a middle-income country with P12.18 billion (US\$1.2 billion) in its annual development budget and P27.14 billion (US\$4.17 billion) in its recurrent budget. Its national income per capita (PPP international \$) in 2009 was \$13 310. Total expenditure on health per capita was \$1341 and total expenditure on health as a