



Financing of mental health: the current situation and ways forward

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ACRONYMS

CSR	corporate social responsibility
DAH	development assistance for health
DALYS	disability-adjusted life years
DAMH	development assistance for mental health
DFID	Department for International Development (UK)
FCDO	Foreign, Commonwealth and Development Office (UK)
GDP	gross domestic product
HIC	high-income country
IDA	International Development Association
IFI	international financial institution
IHME	the Institution for Health Metrics and Evaluation
LIC	low-income country
LMICs	lower-middle-income countries
MHA	Mental Health Atlas
MHIC	mental health investment case
MHPSS	mental health and psychosocial support
NCDs	noncommunicable diseases
NGO	non-governmental organisation
ODA	official development assistance
ODI	the Overseas Development Institute
OECD	the Organisation for Economic Co-operation and Development
OECD DAC	the OECD's Development Assistance Committee
OOP	out-of-pocket expenditures
PEPFAR	the US President's Emergency Plan for AIDS Relief
PPPA	per person per annum
PROGRESA	Programa de Educación, Salud y Alimentación (Mexico)
SIB	social impact bond
UHC	universal health coverage
UMIC	upper-middle-income country
USAID	the United States Agency for International Development
WHO	World Health Organisation
YLDs	years of healthy life lost to disability
YLLs	years of life lost to premature mortality

EXECUTIVE SUMMARY

Globally, almost one billion people are living with a mental health condition, including around one in seven teenagers.¹ The past decade has also seen a 13% rise in mental health conditions and substance abuse.² In light of this increasing need, what is being done to finance mental health services around the world?

Domestic financing is the most important source of funding for mental health, but it rarely covers needs. External organisations do help to fill these financing gaps, but seldom is it enough. Moving forwards, it is clear that mental healthcare needs not only more financial resources, but also more effective and efficient use of sustainable resources currently available. Innovative financing, integration across budgets and inclusion in global financing partnerships could all be used to prioritise mental health in a world of competing agendas.

Domestic financing for mental health

Despite some positive examples, in general, governments spending on mental health has not increased considerably – and is nowhere near the required amount – with no significant increase reported between 2017 and 2020 (the most recent set of data available). Of the 85 countries that provided data in 2020, only 13 met the Lancet expenditure targets (5% for LICs, LMICs and UMICs, and 10% for HICs, as a proportion of the domestic health budget). Of these 13, five were high-income countries (Barbados, France, Germany, the Netherlands and Norway), six were upper-middle-income countries (Jamaica, Marshall Islands, Mauritius, North Macedonia, Saint Vincent and the Grenadines, and South Africa) and two were lower-middle-income countries (Kiribati and Lebanon). Nine of these countries report the proportion of mental health financing that is allocated to psychiatric hospitals, with the median percentage being 7.1%. The median gap between domestic resources and the target was 3.7 percentage points of government health budgets in 2020. Many LICs were a long way behind, with median spend 4.9 percentage points behind the target. While HICs need to increase their mental health allocations by 5.4 percentage points to reach the suggested minimum amount. Currently, there is no sign of growth in the proportion of health financing going to mental health.

1 Nearly one billion people have a mental disorder: WHO, 2022, <https://news.un.org/en/story/2022/06/1120682>, Accessed: 28 August 2023

2 Health topics: Mental health, https://www.who.int/health-topics/mental-health#tab=tab_2, Accessed: 28 August 2023.

Mental health spending is lower than spending on many other health issues, despite being a large contributor to poor health for a whole host of historical and contemporary reasons. In 2019, substance abuse and neurological and mental health conditions across all ages together accounted for one in 10 DALYs (10.1%) worldwide.³ Mental illness accounted for 5.1% of the global burden, whereas neurological conditions accounted for 3.5% and substance abuse, 1.5%.

Approximately US\$38 million is spent on mental health domestically in LICs and US\$1.5 billion in LMICs, with considerably more spent in UMICs and HICs in volume terms. This leaves a global financing gap of more than US\$200 billion. In LICs, the gap is US\$219 million and in LMICs US\$3,081 million. In UMICs and HICs, these gaps are even greater in volume terms: US\$26 billion and US\$186 billion respectively. For LICs and LMICs to reach basic mental healthcare provision, LICs would need to increase funding fivefold⁴ while LMICs would need to double their current financial support.

External financing for mental health

Both the private sector and development organisations (bilateral government, multilateral donors, international financial institutions and philanthropic bodies) help fill the identified funding gap by financing mental healthcare across the globe. Development organisations provided over US\$200 million in Development Assistance for Mental Health (DAMH) in 2021, a considerable decrease from the US\$300 million provided in 2018. In the two most recent years with available data – 2020 and 2021 – private/philanthropic donors were responsible for over half of the DAMH provided (56% and 60% respectively) while bilateral donors provided less (41% and 36%). The majority of finance from bilateral donors is not channelled bilaterally, with much of it spent through multilateral organisations. Over the past decade, 57% of bilaterally sourced mental health financing has been channelled through multilaterals. In all of those years except one, the aid channelled multilaterally outweighed that provided bilaterally.

This DAMH makes up some of the gap in LICs and LMICs, contributing more than US\$170 million in 2021 and increasing their mental health spending by around 10%. LICs spend less domestically on mental health, so DAMH increases total spending more than threefold and closes the funding gap by around a quarter. DAMH has less impact on LMICs due to these countries' much larger domestic mental health spend, increasing total spend by around 5%. However, this still leaves a gap of more than US\$3 billion across all LICs and LMICs. With the proportion of health finance allocated to mental health stagnating in recent years, this deficit is unlikely to change without renewed and substantially higher commitments.

3 World mental health report: transforming mental health for all. Geneva: World Health Organisation; 2022.

4 Caddick H, Horne B, Mackenzie J, Tilley H. Investing in mental health in low-income countries, ODI, 2016.

Changes required in mental health financing

Mental health financing requires: (1) an increase in the volume of financing available; (2) more efficient and effective use of the available financing; and (3) predictable and sustainable finance - this report will examine the first two requirements.

Governments should increase their mental health financing to 5% of their total health spend (for LICs, LMICs and UMICs) or to 10% (for HICs). DAC members should allocate at least 0.5% of their overall health development financing to mental health, to commit an extra US\$179 million to mental health services in LMICs. If this was increased to 1%, there would be an extra US\$446 million available.

Governments should incorporate mental health into the budgets and programmes of other ministries beyond the health, including off-budget programmes, however, this has to be well coordinated. Development organisations of all types should incorporate mental health into more of their projects. If just 10% of development assistance for health (DAH) projects had a significant mental health-related aim – despite it not being the principal aim of the project – this could increase funding where mental health is a considered component by over US\$5 billion. For this to be effective, there must be a universally agreed upon definition of what should be included in projects with a significant mental health aim, building on past research analysing DAMH. Global financing partnerships, such as the Global Fund and PEPFAR, have already integrated mental health into their programming. However, others such as the International Development Association, the Global Financing Facility and new climate funds could all include mental health as a priority to help accelerate efforts to reach their stated development goals. Innovative finance mechanisms such as social impact bonds (SIBs) for mental health are an opportunity to access new financing streams, with the Healthy Brains Global Initiative being a new example of an outcomes-based model.

RECOMMENDATIONS

- The [2018 Lancet Commission's](#) government spending targets of at least 5 and 10% of health budgets should be met by all governments. These targets should also be reviewed to continue progress and a cross-government spending guideline considered. This includes tracking expenditures for different types of mental health services in healthcare and other relevant sectors such as education, employment, criminal justice and social services.
- Every national government should conduct regular mental health investment cases to inform national mental health plans and policies.
- Donors should provide at least 0.5% of their DAH to mental health, with this increasing to 1% over time.
- Donors should consider developing dedicated global mental health strategies which recognise mental health as both a fundamental goal in and of itself as well as a critical enabler of wider sustainable development. The strategies should incorporate mental health prevention and promotion; mental health as a critical component of universal health coverage; MHPSS as a critical component of humanitarian response; and global mental health research. They should also be fully integrated into wider ODA strategies as part of a mental-health-in-all-policies approach.
- There should be a universally agreed upon definition for development assistance for mental health (DAMH) and this definition should be used to systematically report on and analyse DAMH flows. This could take the form of a policy marker in the OECD DAC Creditor Reporting System.
- Research should build on past studies that analysed DAMH based on the OECD DAC Creditor Reporting System. This will help provide more up-to-date, granular data on DAMH trends and project themes.



INTRODUCTION

Globally, almost one billion people are living with a mental health condition, including around one in seven teenagers.¹ The effect of this on quality of life is substantial. Substance abuse, mental health and neurological conditions across all ages together account for one in 10 disability-adjusted life years (DALYs) worldwide.² With increasing prominence of external factors such as future pandemics and climate change, the risk of worsening mental wellbeing is considerable.³ It is perhaps not surprising, then, that the last decade has seen a 13% rise in mental health conditions and substance abuse.⁴

In light of this increasing need, what is being done to finance mental health services around the world? Domestic financing is the most important source of funding for mental health, but it rarely covers needs, particularly in low- and middle-income countries (LMICs). External organisations do help to fill these financing gaps, but seldom is it enough. Moving forwards, it is clear that mental healthcare needs not only more financial resources, but also more effective and efficient use of those resources currently available. Innovative financing, integration across budgets and inclusion in global financing partnerships could all be used to prioritise mental health in a world of competing agendas. Poor data availability also poses a problem for transparency, efficiency and accountability. So more thorough and joined-up reporting on financing for mental health is vital.

The paper focuses on:

- domestic financing for mental health
- external financing and the extent to which it fills the current funding gap
- the changes required to mental health financing to ensure widespread provision of mental health services.

¹ Nearly one billion people have a mental disorder: WHO, 2022, <https://news.un.org/en/story/2022/06/1120682>, Accessed: 28 August 2023.

² Mental health atlas 2020. Geneva: World Health Organisation; 2021.

³ Lawrance EL, Jennings N, Kioupi V, Thompson R, Diffey J, Vercammen A. Psychological responses, mental health, and sense of agency for the dual challenges of climate change and the COVID-19 pandemic in young people in the UK: an online survey study. *Lancet Planet Health*. 2022, doi: 10.1016/S2542-5196(22)00172-3.

⁴ Health topics: Mental health, https://www.who.int/health-topics/mental-health#tab=tab_2, Accessed: 28 August 2023.

DOMESTIC FINANCING FOR MENTAL HEALTH

In 2001, the WHO created a [Mental Health Atlas \(MHA\)](#) to which 78 of 194 member states reported their financing for mental health as a proportion of their overall health budgets. Since then, the WHO has updated these figures every three years. Despite some comparison difficulties due to methodological factors,⁵ the MHA provides an insight into how domestic financing of mental health has changed over time, its current level and how it may change in the future. There are some positive examples, but government spending on mental health has generally plateaued and is nowhere near the required amount, with no significant increase between 2017 and 2020 (the years of the latest editions of the MHA). Without new approaches to mental health financing sources and expenditure, this is unlikely to change.

HOW MUCH HAVE GOVERNMENTS SPENT ON MENTAL HEALTH, HOW MUCH ARE THEY SPENDING NOW AND WHAT IS THE LIKELY SCENARIO IN THE FUTURE?

The majority of financing for mental health globally comes from domestic government budgets. However, the size of these budgets varies greatly by country and they are typically low. As of 2020, the global median of public spending on mental health was just 2.1% of government health expenditure.

The latest estimate for required investment in mental health was made in [The Lancet Commission on Global Mental Health and Sustainable Development](#) in 2018. The report stated that although an assessment of exact needs is best practice, governments in LMICs should spend at least 5% of their health budgets on mental health, while HICs should spend 10%. The paper also noted that this spending should be in addition to other funding priorities that partially incorporate mental health. Of the 85 countries that provided data in 2020, only 13 met these expenditure targets. Five were high-income countries (Barbados, France, Germany, Netherlands and Norway), six were upper-middle-income countries (Jamaica, Marshall Islands, Mauritius, North Macedonia, Saint Vincent and the Grenadines, and South Africa) and two were lower-middle-income countries (Kiribati and Lebanon).⁶

Nine of these countries report their proportion of mental health financing that goes to mental hospitals, and the median percentage is 7.1%.⁷ There have been calls for amendments to these guidelines, such as raising UMICs' target to 7.5% and/or changing the denominator to be the overall government budget rather than just health to reflect the emerging 'mental-health-in-all policies approach'.

In many LMICs, these are small proportions of already very small health budgets. This means the magnitudes are very low in dollar terms. In 2020, LICs' median mental health spend was just US\$0.02 per person per annum (PPPA), while LMICs' was US\$0.34. In five LICs and two LMICs, the amount spent on mental health was equivalent to less than \$0.01 PPPA. In comparison, UMICs spent an average of US\$4.97 PPPA and HICs spent in excess of US\$50 PPPA, a significant difference in spend between country income groups.

There was no improvement in the proportion of government health budgets being spent on mental health between 2017 and 2020, with the share staying roughly constant at around 2%.⁸ In 2017, the median proportion of HICs' health spend dedicated to mental health was 5.2%. However, in LMICs, this figure was only 2%. These figures stayed roughly constant into 2020 with HICs' proportional spend increasing slightly to 5.4% and LMICs increasing slightly to 2.1%.

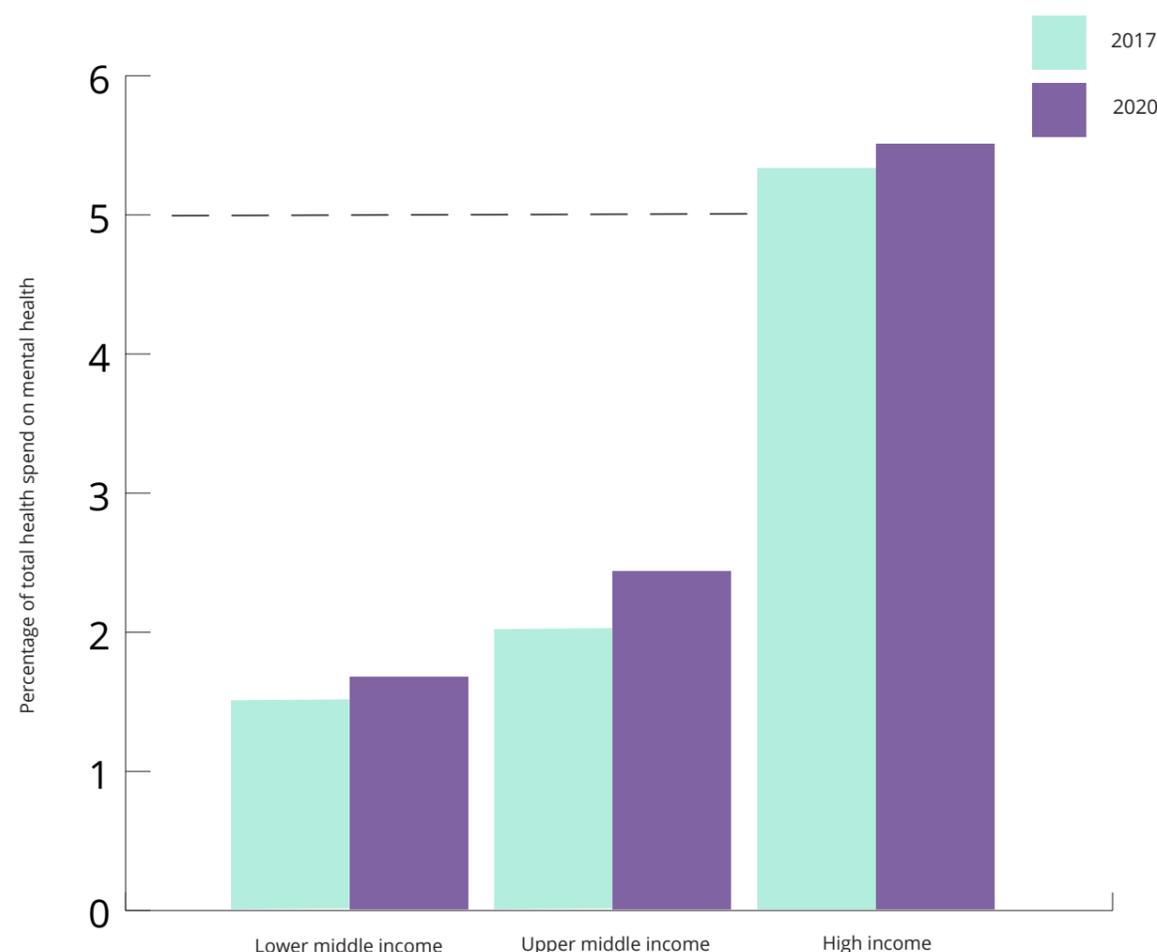
7 WHO Global Health Observatory, Government expenditures on mental health as a percentage of total government expenditures on health (%)

8 Mental health atlas 2020. Geneva: World Health Organization; 2021.

5 Mental Health Atlas 2020. Geneva: World Health Organisation; 2021.

6 Countdown Global Mental Health Report 2030: Making Mental Health Count, 2023.

Figure 1: Domestic mental health expenditure as a proportion of overall domestic health expenditure by income group, 2017–2020



Source: Mental health atlas 2017 and 2020. Geneva: World Health Organization; 2018 and 2021.

Notes: Only countries which reported figures in both 2017 and 2020 are included. The dashed lines represent the target percentages in the Lancet Commission 2018 paper. There is very limited information on low-income countries. Only two reported mental health spend figures to both Mental Health Atlases and so are not considered representative enough to display.

Despite there being no clear increased prioritisation of mental health within the health sector, health spending has generally increased globally. Therefore, despite the proportions of mental health spending remaining constant, per capita financing of mental health by those countries reporting to the WHO Mental Health Atlas increased from US\$2.50 in 2017 to US\$7.49 in 2020. However, there are issues with comparability due to variation of countries reporting and the volumes they report.

Further, this has not been a uniform increase.⁹ Government spending on health increased in UMICs and HICs, while it remained constant in LMICs, and declined in LICs between 2000 and 2011 before rebounding in more recent years.¹⁰

This lack of increase in the size of domestic mental health financing in recent years is concerning given the growing need. Currently, the proportion of health financing going to mental health shows no sign of rising, so it will still take a considerable amount of time to reach a figure which truly addresses the need.

This is despite the considerable return on investment in mental health services: a return of greater than one for productivity gains alone and greater than two when the intrinsic economic value of health is also considered. These returns on investment should be highly appealing to government budget decision-makers, returns that can be as high as four times in some countries.¹¹ Private companies receive a US\$5 return on average for every US\$1 invested in employee mental health and wellbeing.¹² There is of course a case for improved mental health support beyond the financial return as the need for mental health support grows. As we will see later in the paper, that support is held back by the lack of public investment.

Reporting mental health finance

There are substantial limitations when it comes to analysing self-reported government mental-health budgets as a proportion of overall health budgets. These include inconsistent reporting by governments, differences in definitions of what is included, and widespread incomplete data. Despite an increase in the number of countries reporting in 2020 compared to 2017 (from 79 up to 85), of the 110 countries that reported in either 2017 and/or 2020, only 54 reported on both occasions. As a result, two consistent data points are only available for less than one-third of countries in the world.

Most notably, in the self-reporting of mental health budgets to the WHO MHA, mental health spending integrated across the health system and elsewhere is not taken into account. Financing decisions are not made in an isolated manner – domestically, they are made at both a health- and finance-ministry level.

⁹ Mental health atlas 2020. Geneva: World Health Organisation; 2021.

¹⁰ Global expenditure on health: Public spending on the rise? Geneva: World Health Organisation; 2021.

¹¹ Chisholm D, Sweeny K, Sheehan P, Rasmussen B, Smit F, Cuijpers P, et al. Scaling-up treatment of depression and anxiety: a global return on investment analysis. *Lancet Psychiatry*. 2016. doi: 10.1016/S2215-0366(16)30024-4.

¹² The return on the individual: time to invest in mental health, *Speak your mind*, 2020.

There have been attempts to quantify indirect financing to mental health in general programmes, but this is difficult as health accounting lags behind. It is also yet to be decided what can and should be included as mental health finance. If domestic governments are encouraged to incorporate mental health more generally in a mental-health-in-all-policies approach,¹³ it is important that there is a strong framework for quantifying how much of each element can be counted towards mental health. This increases the incentive for a mental-health-in-all-policies approach and allows for more transparency and accountability.

HOW DOES THE FINANCING OF MENTAL HEALTH DIFFER TO FINANCING OF OTHER HEALTH ISSUES?

Mental health spending is lower than that for many other health issues – relative to the disease burden – for a whole host of historical and contemporary reasons. These include stigma and discrimination, lack of political will, and a lag in the gathering of strong evidence on the benefits of tackling the problem.

Almost 90% of people with mental ill health in the UK say that stigma and discrimination have a negative effect on their lives,¹⁴ and structural discrimination of people living with mental illness remains common.¹⁵ As a result, there has not been the same political pressure as for other issues and no large increase in political will to make positive changes.

The burden of mental health conditions is considerable. It can be measured using metrics such as years of life lost to premature mortality (YLLs), years of healthy life lost to disability (YLDs) and disability-adjusted life years (DALYs) – a combination of YLLs and YLDs.¹⁶ In 2019, substance abuse and neurological and mental health conditions across all ages together accounted for one in 10 DALYs (10.1%) worldwide.¹⁷ Mental illness accounted for 5.1% of the global burden, whereas neurological conditions accounted for 3.5% and substance abuse, 1.5%.

13 Mental Health in all Policies, <https://mentalhealthandwellbeing.eu/mental-health-in-all-policies/>, Accessed: 28 August 2023.

14 Stigma and discrimination, <https://www.mentalhealth.org.uk/explore-mental-health/a-z-topics/stigma-and-discrimination>, Accessed: 28 August 2023.

15 Rössler W. The stigma of mental disorders: A millennia-long history of social exclusion and prejudices. *EMBO Rep*. 2016. doi: 10.15252/embr.201643041.

16 DALYs were introduced in the 1990s as a way to compare the state of a population's health between countries in a more detailed manner than simply life expectancy. This had the effect of showing the extent to which some health conditions greatly affect a population, even if they do not end lives prematurely. Mental illness is one example where the effect on a population is much greater than just years of life lost – this is partially because YLL does not attribute any deaths to conditions such as depression or bipolar disorder and includes self-harm and suicide under a separate category of intentional injuries.

17 World Mental Health Report: Transforming mental health for all. Geneva: World Health Organisation; 2022.

In 2013, LMICs were allocated less than US\$1 per DALY in development assistance for the treatment of substance abuse and mental health conditions. Despite there being a 300% increase in funding from 1995 to 2013, substance abuse and mental illness still lag behind other health conditions. Nearly US\$150 per DALY was spent on HIV and AIDS in 2013; whereas maternal and neonatal health, TB and malaria all received more than US\$30 per DALY.¹⁸ Development assistance for HIV and AIDS increased at an annualised rate of 22.8% in the first decade of the 21st century and DALYs attributable to HIV and AIDS roughly halved between 2005 and 2019.^{19,20} Comparatively, there has been a 13% increase in mental health conditions during the decade up until 2017.²¹

There are many factors at play when it comes to deciding how much financing a certain element of health should receive. It is necessary to weigh up the cost and the effectiveness of different treatments. In some cases, there may not even be a treatment, or the necessary expertise available to administer a treatment where one exists. It is vital that health financing is used as efficiently as possible, but even with this caveat, it is clear that mental health is not funded to an appropriate level.

HOW FAR AWAY ARE DOMESTIC BUDGETS FROM FULFILLING NEEDS?

Many different approaches to quantifying the mental health needs of populations have been attempted, but a number of challenges remain. Reliable information on the number of people with mental health conditions is hard to come by due to underreporting of conditions. Stigma means people are unlikely to come forward and access services to begin with. When they do come forward, they often use non-governmental health services (e.g. charities or community groups) due to public healthcare limitations. The minority who do end up using official services may still not be counted due to a lack of diagnosis or simply poorly joined-up systems of reporting.

18 Charlson FJ, Dieleman J, Singh L, Whiteford HA, Donor Financing of Global Mental Health, 1995–2015: An Assessment of Trends, Channels, and Alignment with the Disease Burden. 2017. doi: 10.1371/journal.pone.0169384

19 Tian X, Chen J, Wang X, Xie Y, Zhang X, Han D, Fu H, Yin W and Wu N, Global, regional, and national HIV/AIDS disease burden levels and trends in 1990–2019: A systematic analysis for the global burden of disease 2019 study. 2023. doi: 10.3389/fpubh.2023.1068664

20 Schneider MT, Birger M, Haakenstad A, Singh L, Hamavid H, Chapin A, Murray CJ, Dieleman JL. Tracking development assistance for HIV/AIDS: the international response to a global epidemic. *AIDS*. 2016. doi: 10.1097/QAD.0000000000001081.

21 Health topics: Mental health, https://www.who.int/health-topics/mental-health#tab=tab_2, Accessed: 28 August 2023.

In 2007, the Lancet suggested an investment strategy for a core mental healthcare package in selected LICs and LMICs on a per person per annum (PPPA) basis: at least US\$2 PPPA in LICs and US\$3–4 PPPA in LMICs.²² In a later paper published in 2015, a similar package was estimated to cost US\$3–4 PPPA in LICs and LMICs, and more than double that in UMICs.²³ In 2016, the Overseas Development Institute (ODI) concluded that in LICs, US\$1 PPPA was only enough to provide the most basic services, with US\$2 PPPA a medium-term goal and US\$3 PPPA a longer-term goal to create a more comprehensive service provision.

In addition to absolute targets, there have been examples of relative targets. For instance, in 2021 the WHO stated its aim to increase service coverage for mental health conditions by 50% by 2030.²⁴ While this has the benefit of encouraging all domestic governments to work towards a specific target, it could be seen as an unreasonable goal by countries who already invest significantly in mental healthcare.

Using the Lancet government spending targets (5% for LICs, LMICs and UMICs and 10% for HICs), the median gap between domestic resources and the target was 3.7 percentage points of national health budgets in 2020. Many LICs were a long way behind with median spend 4.9 percentage points behind the target, while HICs need to increase their mental health allocations by 5.4 percentage points to reach the suggested minimum amount.

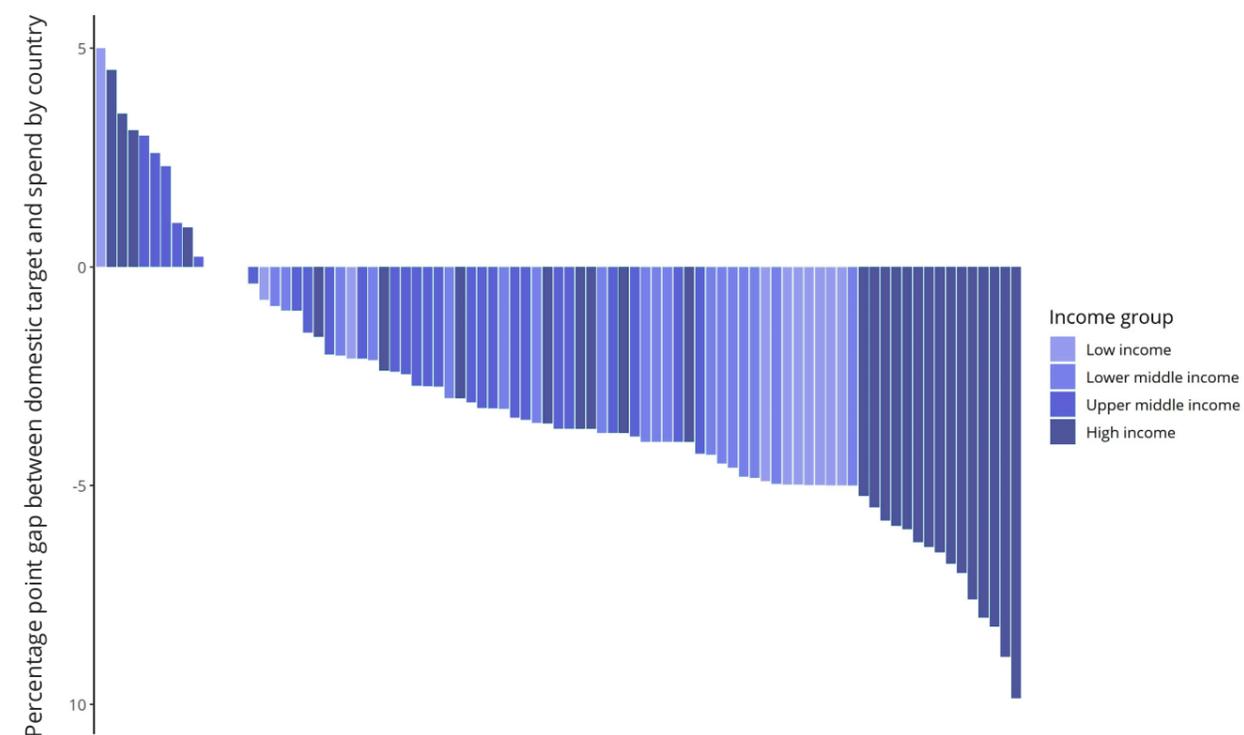
These expenditure targets have mostly been created using general estimates, rather than individual needs assessments at the national level. It is useful for governments and other organisation to have a goal to reach, but these goals do not take into account many of the differences between countries. Characteristics such as the urban-rural ratio, conflict, vulnerability to climate change and inequality can make a big difference to need. The desired level of service is also an important consideration.

22 Scale up services for mental disorders: a call for action, Lancet Global Mental Health Group, 2007, doi: 10.1016/S0140-6736(07)61242-2.

23 Patel V, Chisholm D, Parikh R, et al. Global Priorities for Addressing the Burden of Mental, Neurological, and Substance Use Disorders. In: Patel V, Chisholm D, Dua T, et al., editors. Mental, Neurological, and Substance Use Disorders: Disease Control Priorities, Third Edition (Volume 4). Washington (DC): The International Bank for Reconstruction and Development / The World Bank; 2016. doi: 10.1596/978-1-4648-0426-7_ch1

24 Comprehensive mental health action plan 2013–2030. Geneva: World Health Organisation; 2021.

Figure 2: Gap between the financing target for mental health and actual domestic spend by country in 2020



Source: Mental Health Atlas 2020. Geneva: World Health Organisation, 2021.

Notes: Where the figure plotted is positive, this shows the country exceeded its target from the Lancet Commission 2018 paper.

A handful of countries are exceeding their mental health spending target but these are mostly HICs. In dollar terms, the 85 countries with available data spent between US\$0 and almost US\$1,000 per capita on mental health in 2020. However, the most any LIC spends is US\$0.39 per capita, less than half of the amount needed for the most basic service provision (US\$1 per capita). For LICs and LMICs to reach the 2007 Lancet Commission’s PPPA US\$ targets for basic mental healthcare provision, LICs would need to increase funding fivefold,²⁵ and LMICs would need to double their current financial support.

In the 10 LICs that provide data on domestic expenditure for mental health, a total of US\$19 million per annum is spent on this sector. In the 20 LMICs that report this data, the figure is US\$950 million per annum.

25 Caddick H, Horne B, Mackenzie J, Tilley H. Investing in mental health in low-income countries, ODI, 2016.

Using median figures to approximate countries for their income groups,²⁶ the overall finance available at a domestic level for mental health is more than US\$200 billion. However, more than 90% of this is accounted for by HICs. Approximately US\$38 million is spent domestically in LICs and US\$1.5 billion in LMICs, leaving a gap of around US\$219 million in LICs and US\$3.1 billion in LMICs.

Since some LICs and LMICs do not currently spend anything on mental health – and many do not even report a figure – it is very difficult to forecast how long it will take to reach minimum service levels. The WHO's Comprehensive Mental Health Action Plan 2013–2030 provides the target of a 50% increase in treatment coverage for anxiety, depression, epilepsy, bipolar disorder and psychosis by 2030. This would necessitate an annual increase of just US\$0.20 per capita, with LICs and LMICs requiring only US\$0.004 and US\$0.02 increases respectively because of the low level of current coverage. These increases required for LICs and LMICs are low but should be seen through the lens of current low mental health coverage rates, meaning a 50% increase is also a low target in many settings. To reach universal coverage by 2050, an annual increase of US\$0.26 per capita would be required, with LICs and LMICs requiring US\$0.02 and US\$0.06 increases respectively.²⁷

These considerable gaps in domestic mental health financing result in large out-of-pocket (OOP) expenditures²⁸ for many people living with mental illness. Overall OOP health expenditure as a proportion of all health expenditure fell from 18% in 2019 to 16.4% in 2020, probably due at least in part to the COVID pandemic.²⁹ In general, however, OOP expenditures for non-communicable diseases (NCDs) are higher than those for the overall health sector.³⁰ According to the Who Mental Health Atlas, in two-thirds of countries with data, the majority of people pay less than 20% towards their mental health services. This leaves one-third where the majority of people pay in excess of 20% towards any mental health service they use. One study in Mexico found the incidence of catastrophic health expenditure among households of people with a mental illness was 34.8%.³¹

26 Low-income - 0.5%, Lower-middle-income - 1.5%, Upper-middle-income - 2.0%, High-income - 4.0%. In 'Investing in mental health in low-income countries' [ODI, 2016], 0.5% of Total Health Expenditure (THE) is used as an estimate for low-income countries. Other percentages are based on median percentages of THE from those countries with available data, taking into account the large levels of uncertainty.

27 Financing mental health for all, United for Global Mental Health, 2022.

28 OOP expenditures are defined by the WHO as any spending incurred by a household when any member uses a health good or service to receive any type of care.

29 World Health Organisation Global Health Expenditure database, apps.who.int/nha/database, accessed on: 14 September 2023.

30 Matthew R et al, Out-of-pocket expenditure on non-communicable diseases during Covid-19. A cross-sectional study from a semi-urban area of Kannur, Kerala, 2022, doi: 10.1136/bmjgh-2019-001826.

31 Diaz-Castro L, Incidence of catastrophic healthcare expenditure and its main determinants in Mexican households caring for a person with a mental disorder, 2021, doi: 10.1017/gmh.2020.29.

EXTERNAL FINANCING FOR MENTAL HEALTH

As well as domestic financing from country governments, external organisations also finance mental health around the world to help fill the identified funding gap. Although some development organisations provide good levels of support for mental health, many do not. Development assistance for mental health (DAMH) needs to be increased and better coordinated to partially and catalytically fill the finance gap where domestic spending is not sufficient. Other actors, such as those in the private sector, are playing an increasingly important role, and this must be encouraged along with more transparency around their activities.

WHAT ARE THE MOST PROMINENT SOURCES OF EXTERNAL FINANCING FOR MENTAL HEALTH?

Traditionally, global health financing literature has focused mainly on donors (including bilateral donors, multilateral organisations, international financial institutions and philanthropic bodies) as a primary source of funding to implementing institutions providing support in recipient countries (such as development agencies and non-governmental organisations – both local and international).³²

In many countries, other groups such as faith organisations and NGOs have also responded to the increased level of need for mental health services and support. There has been an increasing focus on the private sector and its role in financing the improvement of mental health too. There are two prominent types of private-sector actors: corporations and philanthropic organisations. Corporations provide foreign investment through:

- foreign direct investments (physical investments and purchases)
- foreign portfolio investments (indirect investments through equity and debt)
- corporate social responsibility (CSR: in-kind finances and human resources).

The vast majority of this finance is non-concessional.

Conversely, philanthropic organisations (such as the Bill & Melinda Gates Foundation), are created by high-net-worth individuals or companies and usually provide concessional grant funding for development projects, particularly healthcare programmes.³³

32 Lemmi V, Sustainable development for global mental health: a typology and systematic evidence mapping of external actors in low-income and middle-income countries, 2019, doi: 10.1136/bmjgh-2019-001826

33 Ibid.

Some philanthropic organisations report their DAMH in a similar manner to bilateral and multilateral organisations.

Aside from development actors such as bilateral and multilateral donors, international financial institutions (IFIs) and philanthropic organisations, there is very limited information on other relevant bodies. This makes it hard to establish what the prominent external financing sources are, since we cannot compare these external actors to private-sector and third-sector organisations where data is more limited. It is also difficult to compare the types of financing due to differences in the concessionality of funding.

Development actors report their development assistance to the OECD Development Assistance Committee Creditor Reporting System (DAC CRS). Next, the Institution for Health Metrics and Evaluation (IHME) analyses this data to estimate the quantity of DAMH, providing a robust approximation of volumes. These donors provided over US\$200 million in DAMH in 2021, a considerable decrease from the US\$300 million provided in 2018.³⁴ The largest amounts of financing for mental health came from private/philanthropic donors and bilateral actors, with both being the most significant sources of financing five years out of the last 10 with available data (2012 to 2021). In the two most recent years with available data – 2020 and 2021 – private donors were responsible for over half the DAMH provided (56% and 60% respectively), while bilateral donors provided less (41% and 36% respectively).³⁵

34 Development Assistance for Mental Health 2023, United for Global Mental Health, 2023.

35 Based on Institute for Health Metrics and Evaluation (IHME). Development Assistance for Health Database 1990-2021. Seattle, United States of America: Institute for Health Metrics and Evaluation (IHME), 2023.

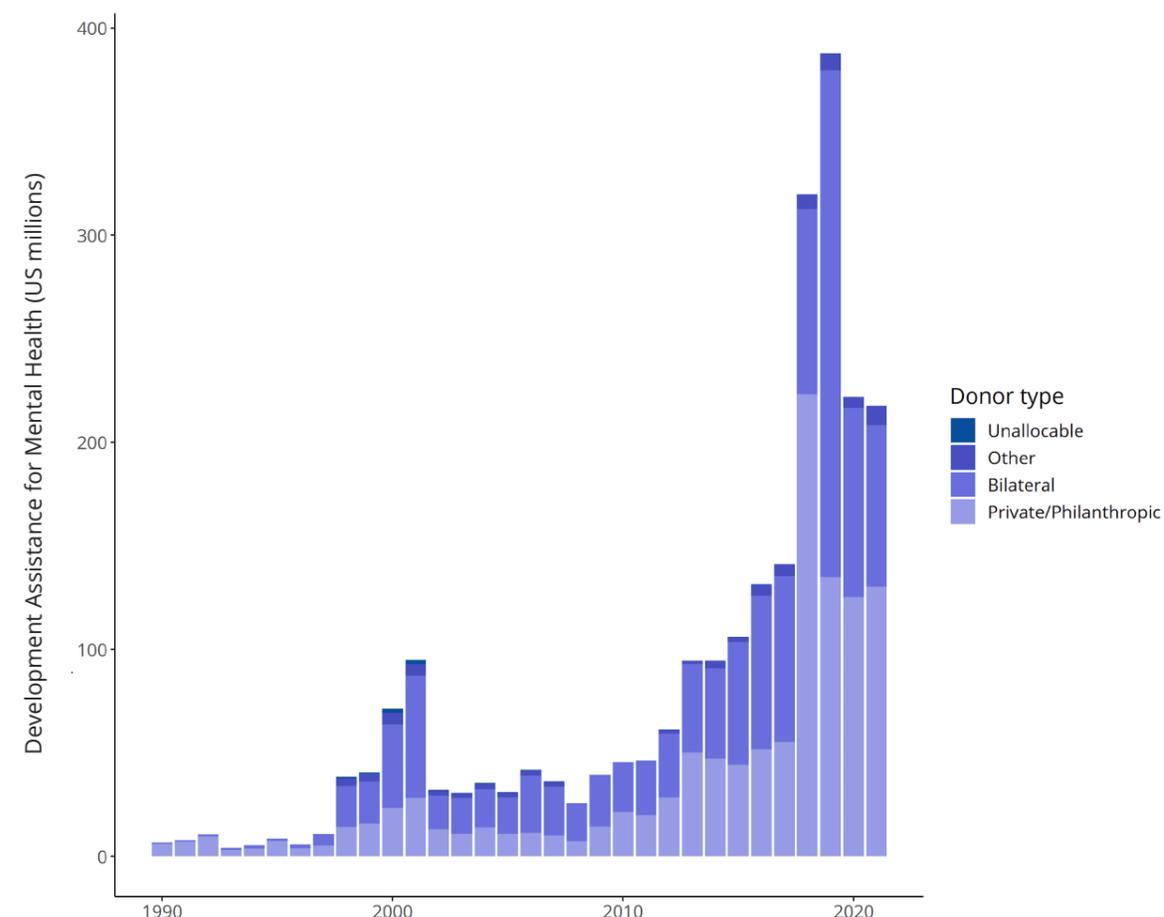


Figure 3: Development assistance for mental health (DAMH), 1990–2021

Source: Institute for Health Metrics and Evaluation (IHME). Development Assistance for Health Database 1990-2021. Seattle, United States of America: Institute for Health Metrics and Evaluation (IHME), 2023.

Despite private/philanthropic donors providing large volumes of DAMH, the bulk of these are not specified within the IHME DAMH database and it is not clear who they are or where they are based. Furthermore, of all health issues, mental health conditions received the lowest amount of philanthropic development assistance for health (DAH) at 0.5% between 2000 and 2015. There is slightly more transparency around where the money is channelled, with the most common channels being NGOs (US\$254 million), followed by US foundations (US\$79 million) and multilateral governmental organisations (US\$31 million). The largest US-based foundations for philanthropic DAMH in the same period were the Ford Foundation (US\$11 million), the Simons Foundation (US\$7 million) and the Open Society Foundations and Oak Foundation (US\$6 million each).³⁶

36 Lemmi V. Philanthropy for global mental health 2000-2015. Glob Ment Health (Camb). 2020. doi: 10.1017/gmh.2020.2.



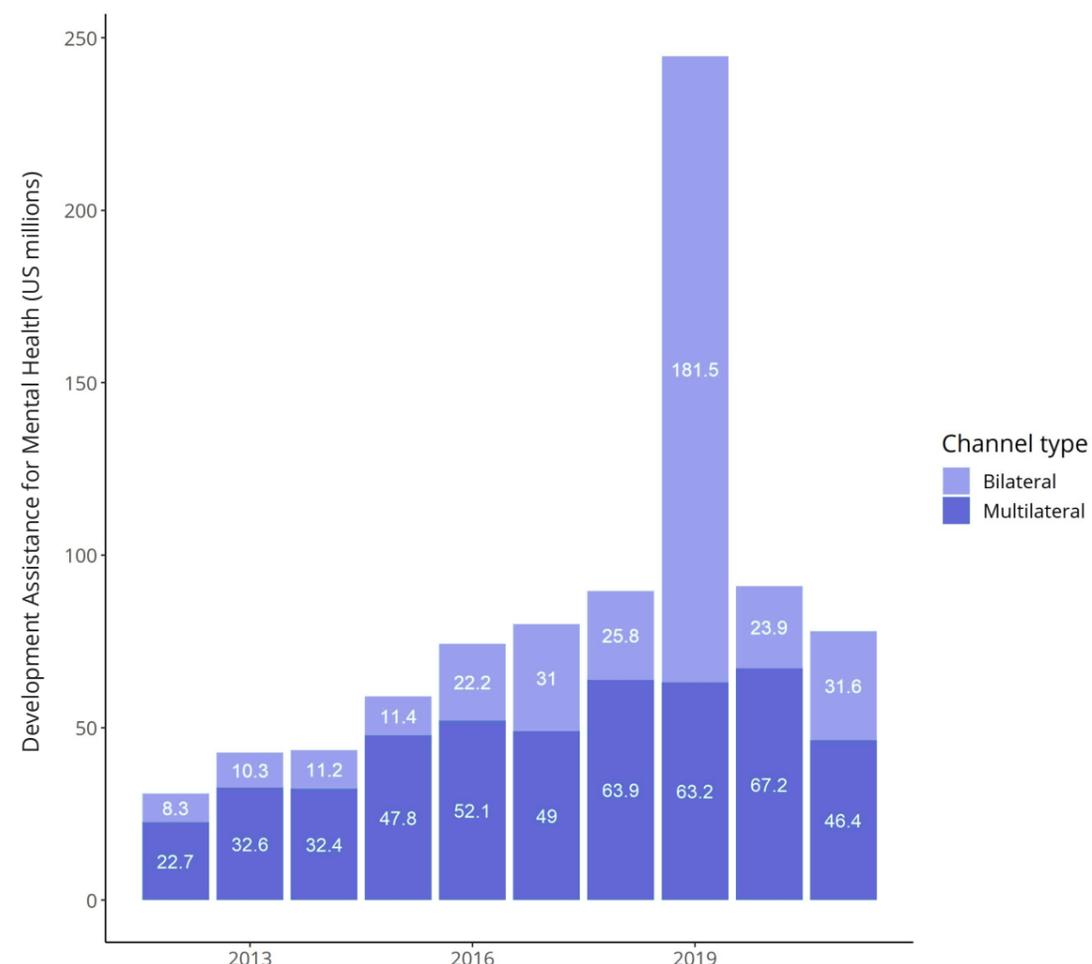
Much of this financing is spent on research in donor countries rather than directly funding mental health services. Further, priorities can change, for example the Open Societies Foundation has since ceased funding work on mental health.

The largest bilateral donors over the last 10 years (2012 to 2021) are clear. The US provided the most funding (US\$269 million), followed by the UK (US\$155 million) and Germany (US\$58 million). These three donors have ranked consistently among the top-five bilateral donors over the last decade, with the UK and US never having left the top three. Mental health financing is highly concentrated within these three donors, who have funded the majority (58%) of bilateral financing over the last 10 years.

Some studies have found that the humanitarian sector was the largest recipient of DAMH.³⁷ This suggests that much of the financing is directed towards emergency response as opposed to long-term services.

The majority of this finance from bilateral donors is not channelled bilaterally (i.e. directly to individual countries) and is instead spent through multilateral organisations. Over the last 10 years, 57% of bilaterally sourced mental health financing has been channelled through multilaterals. In all years except one, the aid channelled multilaterally outweighed that provided bilaterally. In 2019, US\$181 million of bilaterally sourced DAMH was channelled through bilaterals, of which US\$139 million was delivered bilaterally by the US. Despite this anomaly, it is common for bilaterals to channel their DAMH through multilateral organisations.

Figure 4: Channelling of bilateral development assistance for mental health (DAMH) financing, 2012–2021



Source: Institute for Health Metrics and Evaluation (IHME). Development Assistance for Health Database 1990–2021. Seattle, United States of America: Institute for Health Metrics and Evaluation (IHME), 2023.

Multinational corporations do not just provide financing through philanthropic organisations in the form of DAMH. They also make foreign direct and indirect investments in the mental health sector, as well as CSR in the form of human-resource and in-kind financing. Furthermore, some corporations have invested in the mental health of their employees by improving mental health standards in the workplace.³⁸ However, there is very limited information on the actions of private companies concerning mental health, making it extremely hard to quantify the size of their role compared to development actors.

37 Gribble RSF, Liese BH, Wickremsinhe MN. An analysis of funding patterns in development assistance for mental health: who, when, what, and where. *Glob Ment Health (Camb)*. 2021. doi: 10.1017/gmh.2020.30.

38 Lemmi, Valentina. Motivation and methods of external organisations investing in mental health in low-income and middle-income countries: a qualitative study. *The Lancet Psychiatry*. 8. 2021. doi: 10.1016/S2215-0366(20)30511-3.

Reporting development assistance for mental health

Finding accurate and reliable sources of DAMH to identify financing trends is challenging, partly because there is no universally agreed-upon definition for DAMH. Defining DAMH in its broadest sense as supporting a state of mental wellbeing ensures that synergies between mental health and other sustainable-development goals such as poverty reduction are counted, but risks concealing important projects targeting more acute mental health needs.

In their assessment of DAMH between 2007–2013, Gilbert and colleagues defined DAMH as “aid spent on projects whose primary purpose was promoting mental health or preventing or treating mental and substance-use disorders.”³⁹ This definition was re-used by Liese and colleagues several years later in a similar analysis covering 2006–2016.⁴⁰ There is no categorisation of mental health in the OECD Creditor Reporting System, so both of these studies were forced to rely on the less reliable method of searching for key terms. Being able to distinguish between projects which mention mental health versus projects which target mental health would provide invaluable detail on DAMH for policy-makers and advocacy, but is not readily accessible at present. The possibility of obtaining this information is discussed [later in this paper](#).

TO WHAT EXTENT DOES EXTERNAL FINANCING BRIDGE THE GAP IN FULFILLING NEEDS?

As discussed in the [chapter on domestic finance](#), the gap in financing for mental health is likely to be at least US\$200 billion, with around US\$219 million in LICs and US\$3.1 billion in LMICs - the very large health budgets of HICs account for their making up the vast amount of the gap. It is in these countries where external financing is most important, since overall resource volumes are low and there are far fewer opportunities to mobilise domestic resources.

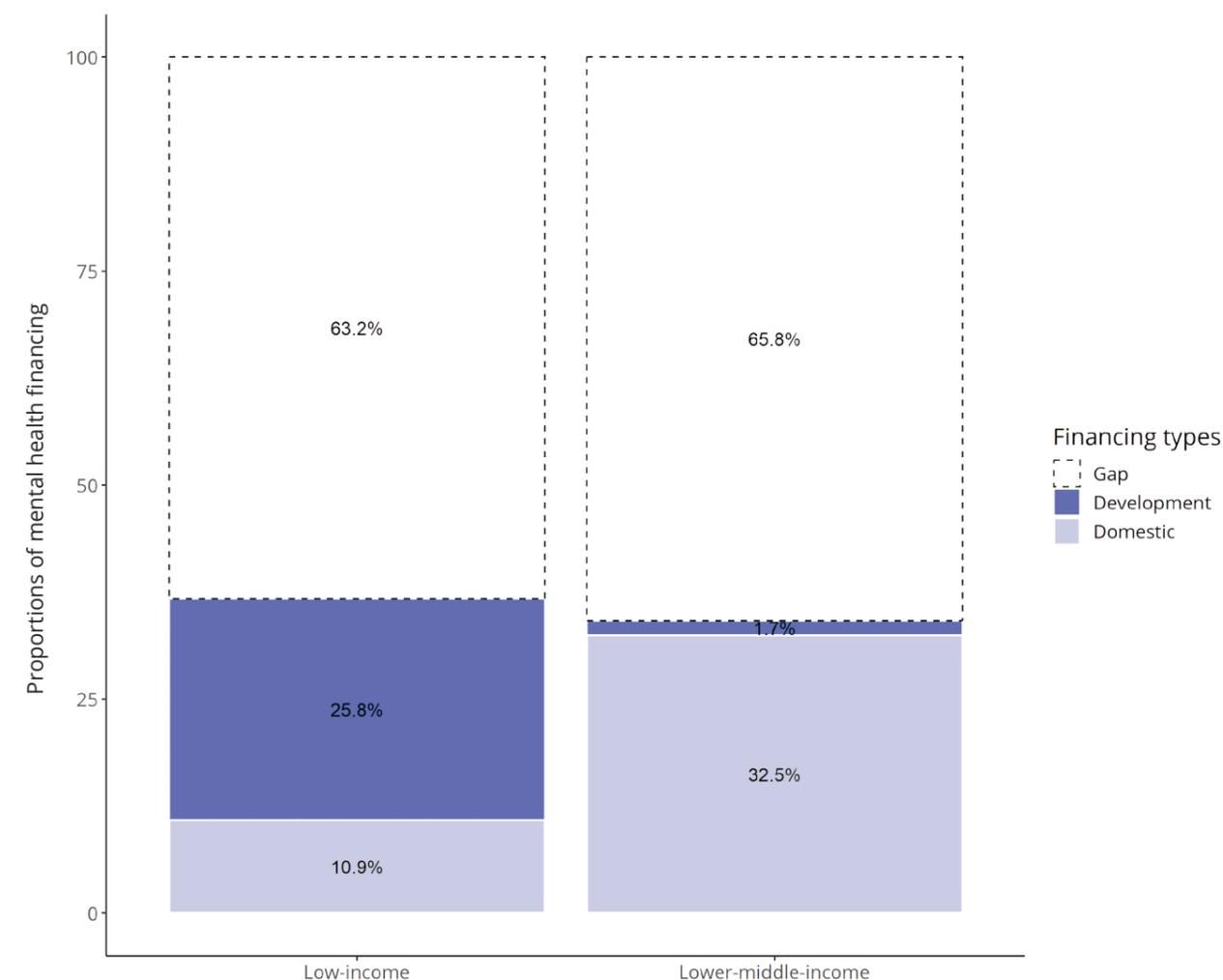
Official development assistance (ODA) targets low- and middle-income countries, with around a third going to the former. However, at an overall development assistance level, much of the financing is channelled through multilaterals and is commonly associated with an unknown or global recipient. It may be that this financing is going to the most in-need countries, but it is difficult to prove that this is the case. The case concerning DAMH is similar. From 2012 to 2021, 83% of DAMH was provided to an unspecified or global recipient. The remainder was heavily concentrated in LICs (7%) and LMICs (6%).

39 Gilbert et al. Assessing Development Assistance for Mental Health in Developing Countries: 2007–2013. 2015. doi: 10.1371/journal.pmed.1001834.

40 Liese et al. An analysis of funding patterns in development assistance for mental health: who, when, what, and where. 2021. doi: 10.1017/gmh.2020.30.

Despite the lack of transparency concerning recipients, this external financing is crucial to pushing forward the mental health agenda and filling gaps in the short-term, particularly in LICs and LMICs. What is unclear is how much of the current financing gap it actually fills.

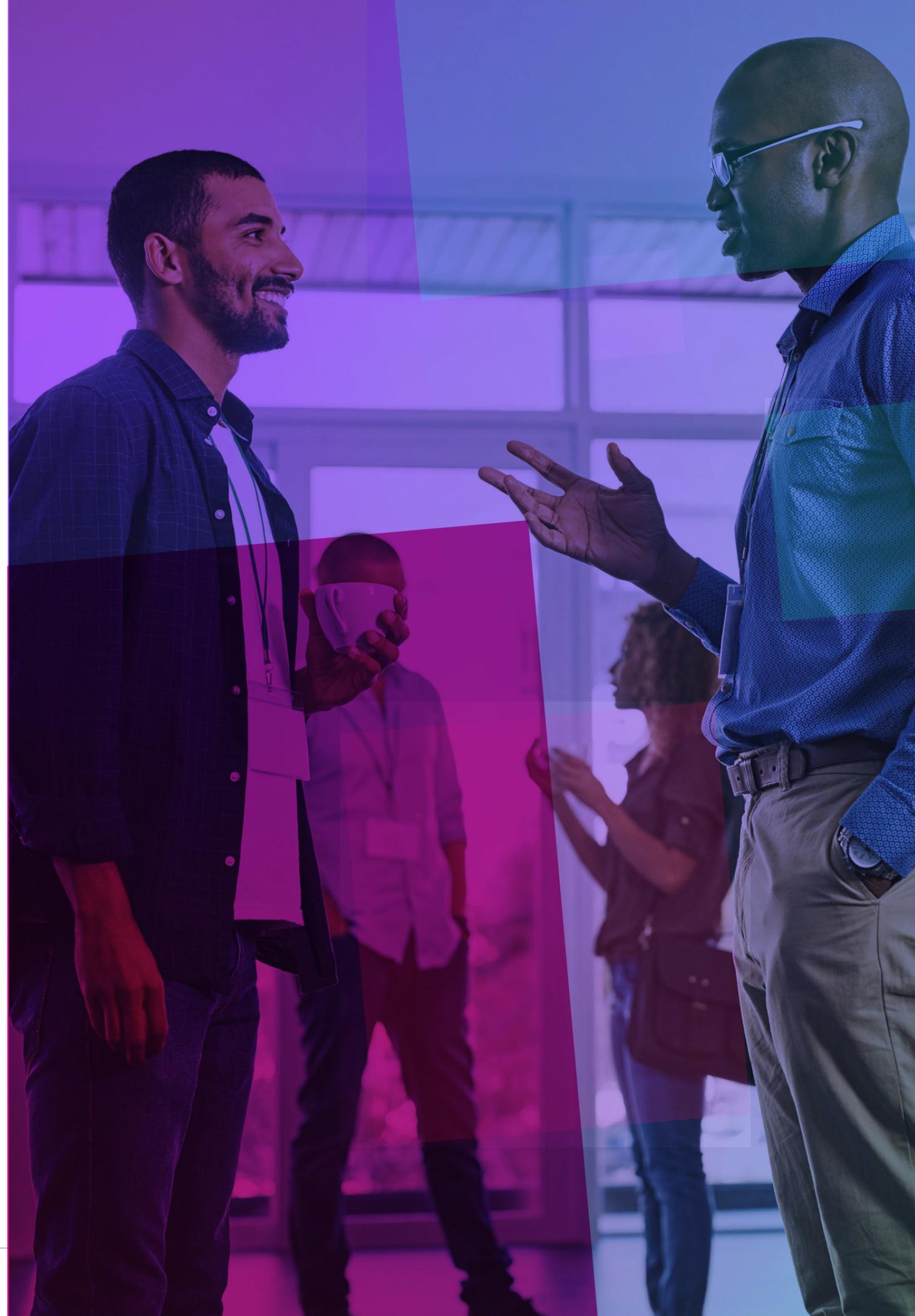
Figure 5: How DAMH partly fills the gap in domestic financing in low- and lower-middle income countries



Source: Based on Institute for Health Metrics and Evaluation (IHME). Development Assistance for Health Database 1990–2021. Seattle, United States of America: Institute for Health Metrics and Evaluation (IHME), 2023.

Without knowing how the 83% of DAMH with an unknown/global recipient is spent, it is unclear exactly how much LIC and LMICs are receiving. However, assuming that the funding is spent in a similar ratio to the activities with specified recipients,⁴¹ we would expect to see US\$89 million (or 25.8% of the overall need) spent in LICs and US\$80 million (or 1.7% of the overall need) spent in LMICs. Overall ODA of nearly US\$170m to LICs and LMICs increases their mental health spending by around 10%. In LICs, which spend less domestically on mental health, this increases total spending more than threefold and closes the gap by around a quarter. The overall effect in LMICs is much smaller due to the much larger domestic spend, increasing spend in the country by around 5%. The assistance provided to UMICs holds even less significance on a proportional basis, with US\$48 million DAMH being provided to these countries.

41 7% LIC, 6% LMIC, 4% UMIC.



CHANGES REQUIRED IN MENTAL HEALTH FINANCING

With such a large gap in financing for mental health, it is vital that stronger mental health services are provided as soon as possible. There are two clear ways to do this:

1. increase the volume of financing available
2. use the available financing in the most efficient and effective manner

Both of these approaches should be incorporated into any plan to improve the state of the world's mental health.

HOW CAN WE FILL THE IDENTIFIED FINANCING GAP?

Using the Lancet Commission 2018 domestic expenditure targets, the global financing gap is greater than US\$200 billion. In LICs, the gap is US\$219 million and in LMICs, US\$3,081 million. In UMICs and HICs, these gaps are even greater in volume terms: US\$26 billion and US\$186 billion respectively. Development Assistance for Mental Health (DAMH) makes up some of this gap in LMICs, contributing more than US\$200 million in 2021. However, this still leaves a gap of over US\$3 billion in LICs and LMICs. With the proportion of health spending going towards mental health stagnating in recent years, this deficit is unlikely to change without action. So where should the money come from?

Domestic mental health budgets in HICs currently average 4.6% – well below the recommended 10% target. Domestic budgets in LMICs are also well below the target of 5%, averaging only 1.7%. As well as improving the integration of mental healthcare, governments in all countries should boost mental health spending to reach the target through increased direct mental health financing. HICs should increase their mental health budgets in line with recommended amounts – despite increased domestic health spend globally, mental health spend is not being prioritised enough in HICs.⁴²

However, in many LMICs, there is reduced capacity to increase this financing through government budgeting. In these cases, development actors must play an important role in both pushing forward the mental health agenda and filling the gap. Development actors – most notably private/philanthropic organisations and bilateral actors – play a sizable role in financing mental health, but there is still room to increase the volumes they provide.

42 Countries are spending more on health, but people are still paying too much out of their own pockets: WHO, 2019, <https://www.who.int/news/item/20-02-2019-countries-are-spending-more-on-health-but-people-are-still-paying-too-much-out-of-their-own-pockets>, Accessed: 28 August 2023.

Return on investment in mental health financing

Aside from improving quality and length of life, investment in mental health also has economic advantages. In some countries, investing US\$1 returns as much as US\$4.⁴³ Furthermore, some particular interventions – such as school-based programmes targeting anxiety, depression and suicide – can have even greater returns.⁴⁴ The State of the World's Children report found that every dollar spent on these interventions over 80 years would return more than US\$20. These returns were projected to be even greater in LICs and LMICs, reaching over US\$80 and US\$60 respectively.⁴⁵ Increased investment in mental health also has a pronounced effect on the direct economic output of many countries. Mental Health Investment Cases (MHICs) in seven LICs and LMICs countries found that the economic burden of mental health conditions was substantial, typically amounting to 0.5%–1.0% of GDP. However, the cost of scaling up intervention packages was only 0.03%–0.14% of GDP.⁴⁶ These investment cases have now been carried out in many countries such as the Philippines, returning evidence of the gains that can result from increased investment.⁴⁷

Recommendation: The [2018 Lancet Commission's](#) government spending targets of at least 5 and 10% of health budgets should be met by all governments. These targets should also be reviewed to continue progress and a cross-government spending guideline considered. This includes tracking expenditures for different types of mental health services in healthcare and other relevant sectors such as education, employment, criminal justice and social services.

Recommendation: Every national government should conduct regular mental health investment cases to inform national mental health plans and policies.

Between 2012 and 2021, bilateral organisations allocated an average of 0.27% of health financing to mental health, compared to philanthropic organisations' 0.40%. Proportionally, the largest bilateral donors were Switzerland (1.21%), Greece (0.80%) and Finland (0.78%).

43 Chisholm D, Sweeny K, Sheehan P, Rasmussen B, Smit F, Cuijpers P, et al. Scaling-up treatment of depression and anxiety: a global return on investment analysis. *Lancet Psychiatry*. 2016. doi: 10.1016/S2215-0366(16)30024-4.

44 Chisholm D, Lee YY, Baral PP, Bhagwat S, Dombrovskiy V, Grafton D, Kontsevaya A, Huque R, Kalani Okware K, Kulikov A, Marahatta K, Mavunganidze P, Omar N, Prasai D, Putoud N, Tsoyi E, Vergara J. Cross-country analysis of national mental health investment case studies in sub-Saharan Africa and Central, South and South-East Asia. *Front Health Serv*. 2023. doi: 10.3389/frhs.2023.1214885.

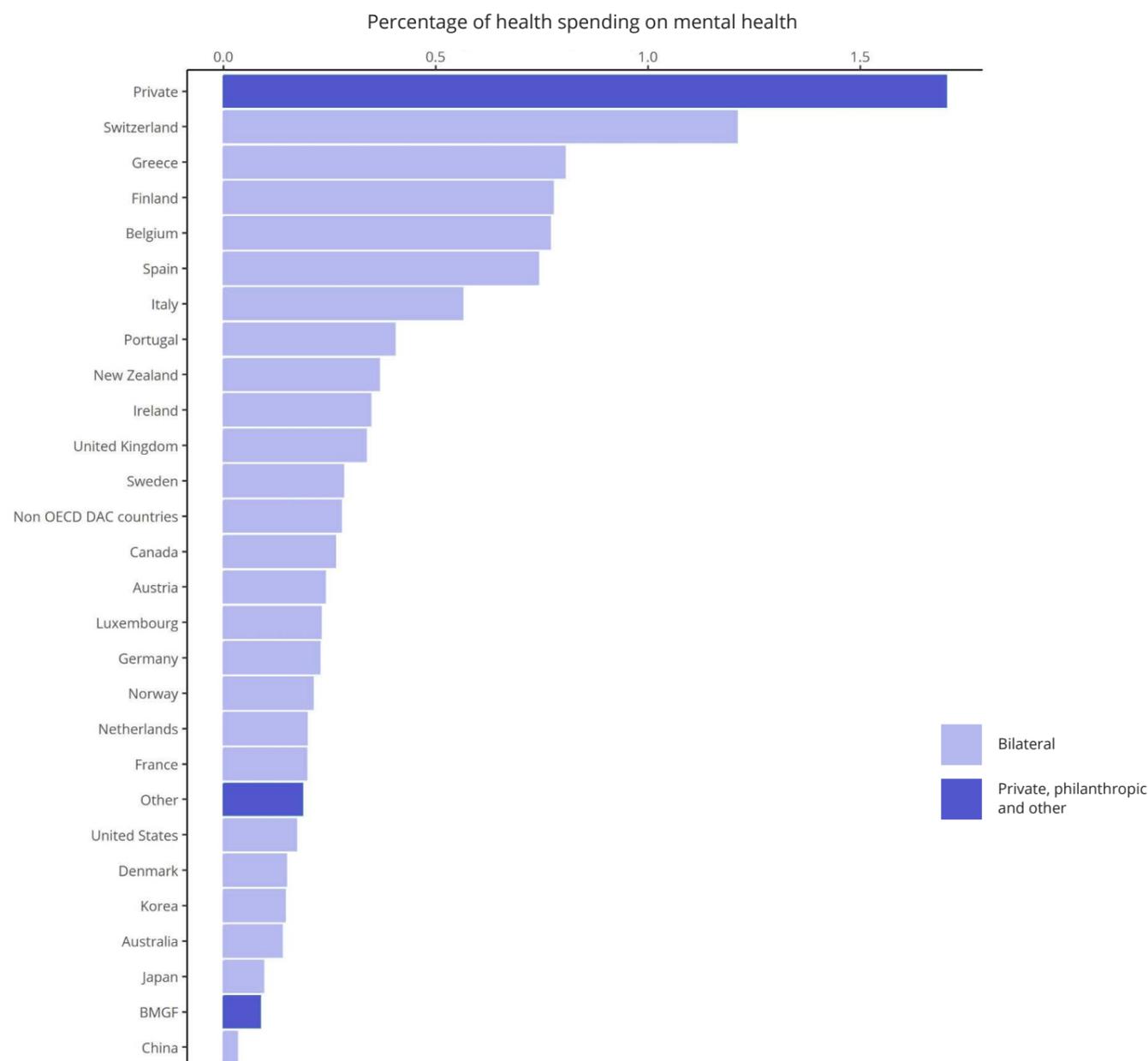
45 Financing mental health for all, United for Global Mental Health, 2022.

46 Chisholm D, Lee YY, Baral PP, Bhagwat S, Dombrovskiy V, Grafton D, Kontsevaya A, Huque R, Kalani Okware K, Kulikov A, Marahatta K, Mavunganidze P, Omar N, Prasai D, Putoud N, Tsoyi E, Vergara J. Cross-country analysis of national mental health investment case studies in sub-Saharan Africa and Central, South and South-East Asia. *Front Health Serv*. 2023. doi: 10.3389/frhs.2023.1214885.

47 The economic case for investing in mental health, UNDP, 2021 Accessed on 14 September 2023.

Private organisations reporting to the OECD DAC CRS allocated US\$812 million (1.7%) of their health budget to mental health, while the largest philanthropic donor, the Bill and Melinda Gates Foundation, provided US\$42 million (0.09%) in DAMH. Overall, only 0.3% of development assistance for health (DAH) was classified as DAMH.

Figure 6: Development assistance for mental health (DAMH) as a proportion of development assistance for health (DAH) from development actors, 2012–2021



Source: Institute for Health Metrics and Evaluation (IHME). Development Assistance for Health Database 1990-2021. Seattle, United States of America: Institute for Health Metrics and Evaluation (IHME), 2023.

According to the Institution for Health Metrics and Evaluation (IHME), DAC members provided US\$68.5 billion of DAH in 2021. If all DAC members allocated at least 0.5% of overall health financing to mental health, there would be an extra US\$179 million available for mental health services in LMICs. If this was increased to 1%, there would be an extra US\$446 million available.

Recommendation: Donors should provide at least 0.5% of their development assistance for health (DAH) to mental health, with this increasing to 1% over time.

Few donor countries have published global mental health strategies. The UK published [An Approach and Theory of Change to Mental Health and Psychosocial Support](#) in 2020, yet this has not been revisited following the incorporation of the Department for International Development (DFID) into the Foreign, Commonwealth and Development Office (FCDO) in 2021. USAID is in the process of developing a standalone mental health strategy. Of those countries with a public global health strategy, few mention mental health and those that do typically only briefly reference wellbeing or mental health and psychosocial support (MHPSS).

Recommendation: Donors should consider developing dedicated global mental health strategies which recognise mental health as both a fundamental goal in and of itself as well as a critical enabler of wider sustainable development. These strategies should incorporate mental health prevention and promotion; mental health as a critical component of universal health coverage; MHPSS as a critical component of humanitarian response; and global mental health research. They should also be fully integrated into wider ODA strategies as part of a mental-health-in-all-policies approach.

Aside from traditional development actors, private corporations have played an increasing role in the health sector. The private sector provides between one-third and three-quarters of all primary health care in LICs.⁴⁸ It is vital that the private sector is engaged to provide quality mental health services in a manner that benefits society while also providing a return on investment. Innovative mechanisms, such as blended finance, which increase the involvement of private sector capital in healthcare, have been widely considered. This is discussed [later in this report](#).⁴⁹

48 Private vs. Public, IMF, <https://www.imf.org/external/pubs/ft/fandd/2014/12/coarasa.htm>, Accessed: 14 September 2023.

49 Kwesiga B, Titi-Ofei R, Nabyonga-Orem J. Attracting private sector inflows to close the financing gap for universal health coverage: What questions need to be answered? *J Glob Health*. 2023. doi: 10.7189/jogh.13.03013.



HOW CAN CURRENT FUNDS BE USED MORE EFFECTIVELY FOR MENTAL HEALTH?

Aside from increasing the funds available for mental health, it is important to use existing funds in a more effective way. Opportunities to improve financing structures include:

- incorporating mental health into the budgets and programmes of other ministries, including off-budget programmes in a coordinated way
- development actors of all types incorporating mental health into more of their projects
- including mental health as a priority in global financing partnerships such as IDA, the Global Financing Facility and new climate funds
- innovative finance mechanisms such as social impact bonds (SIBs) for mental health.

Incorporating mental health into the budgets and programmes of other ministries, including off-budget programmes

The WHO recognises mental health as a key component of universal health coverage (UHC). Furthermore, one of the four major objectives of the WHO's Comprehensive Mental Health Action Plan 2013–2030 is “the provision of comprehensive, integrated mental health and social care services in community-based settings”.⁵⁰ There are considerable benefits to the health of a population when mental health is meaningfully integrated into all policies and not just held in silo. For example, there is a known link between mental and physical health in creating comorbidities (conditions that share the same risk factors but don't directly cause each other), and anxiety and depression are known risk factors for HIV, TB, cardiovascular diseases, diabetes and cancer.⁵¹ So providing cross-cutting finance that allows comorbidities to be treated together tends to be efficient and effective. For example, integrated treatment for comorbid substance abuse and mental illness has been found to be far more effective than the individual diagnosis and treatment of each issue.⁵²

⁵⁰ Comprehensive mental health action plan 2013–2030. Geneva: World Health Organization; 2021.

⁵¹ Hasnain A, Sale J, Kline S, What can we achieve if we meaningfully integrate mental health into UHC?, United for Global Mental Health, 2023.

⁵² NIDA. 2021, April 13. What are the treatments for comorbid substance use disorder and mental health conditions? <https://nida.nih.gov/publications/research-reports/common-comorbidities-substance-use-disorders/what-are-treatments-comorbid-substance-use-disorder-mental-health-conditions>, Accessed: 28 August 2023.

There is even evidence that treatment of more disparate conditions (both physical and mental) together is more effective than conventional care models.⁵³ Providing treatment in this way also allows for more direct analysis of the interrelatedness of comorbidity in service delivery, which is vital to improving quality of care.⁵⁴

Some governments have already begun this integration process. Among these is South Africa, which launched its national strategic plan on NCDs with the inclusion of mental health in September 2022.⁵⁵ Being meaningful included in UHC has the potential to significantly increase financing for mental health.

DEVELOPMENT ACTORS SHOULD INCORPORATE MENTAL HEALTH INTO MORE OF THEIR PROJECTS

Development actors (both bilateral and philanthropic) should mainstream mental health through their programmes, especially those focusing on health. The Global Fund has recently integrated basic mental health and psychosocial services into its new five-year strategy on HIV and TB programmes. This should help millions of vulnerable people and end these co-epidemics at a faster rate and in a more cost-effective way.⁵⁶ If just 10% of DAH projects considered mental health, it could increase funding by over US\$5 billion.

Quantifying the amount of support for mental health in a project that is not mental health-specific is difficult. It is important to decide what should and should not be included as mental health spending when considering the integration of mental health, and there is not a universally agreed definition. In the development sector, the OECD DAC typically uses policy markers, such as the nutrition policy marker. Introduced in 2018, this marker can be applied to projects that are clearly in a nutrition sector or “contribute to a nutrition-sensitive outcome and the project documentation includes an explicit nutrition objective or indicator”.⁵⁷

Tracking mental health investments with a marker would promote mental health mainstreaming and improved outcomes in two ways:

- It would identify opportunities for improved mental health mainstreaming, encouraging the inclusion of mental health objectives or indicators within projects that may not have otherwise included them, while also clearly marking direct mental health projects.
- It would improve transparency and accountability.⁵⁸ A similar marker or methodology could be used to track the changes in cross-sectoral mental health financing from development actors and to encourage its increase.

Recommendation: There should be a universally agreed upon definition for development assistance for mental health (DAMH) and this definition should be used to systematically report on and analyse DAMH flows. This could take the form of a policy marker in the OECD DAC Creditor Reporting System.

Recommendation: Research should build on past research analysing DAMH according to the OECD DAC Creditor Reporting System to provide more up-to-date, granular data on DAMH trends and project themes.

Including mental health as a priority in global financing partnerships

Many global financing partnerships already exist and many more are being created to tackle the largest issues facing society. These include the Global Financing Facility, the Global Partnership for Education, the International Development Association (IDA), the Green Climate Fund and many more. As in the case of the Global Fund, inclusion of mental health as a priority in these partnerships can help raise much-needed financing for the sector, as well as creating treatment efficiencies.

The next IDA replenishment will begin in early 2024 and shareholders will be asked to pledge to the new facility by December 2023.⁵⁹ The most recent replenishment, IDA20, focused on, among other things: gender and development; fragility, conflict and violence; and climate change. The cycle raised US\$93 billion, much of which is being spent in the highlighted target areas.⁶⁰

53 Ee, C., Lake, J., Firth, J. et al. An integrative collaborative care model for people with mental illness and physical comorbidities. *Int J Ment Health Syst* 14, 83. 2020. doi: 10.1186/s13033-020-00410-6.

54 Zulman, D.M., Asch, S.M., Martins, S.B. et al. Quality of Care for Patients with Multiple Chronic Conditions: The Role of Comorbidity Interrelatedness. *J GEN INTERN MED* 29, 529–537. 2014. doi: 10.1007/s11606-013-2616-9.

55 United for Global Mental Health, <https://unitedgmh.org/app/uploads/2023/05/United-Case-Study-South-Africa.pdf>, Accessed: 28 August 2023.

56 United for Global Mental Health, <https://unitedgmh.org/knowledge-hub/mental-health-the-missing-piece-of-the-global-fund-to-fight-aids-tb-and-malaria/>, Accessed: 28 August 2023.

57 The OECD-DAC policy marker on nutrition handbook, OECD DAC, 2022, https://scalingupnutrition.org/wp-content/uploads/2020/12/OECD_PolicyMarkerNutrition.pdf.

58 New data-driven tool shows promise to strengthen multisectoral nutrition investments for better nutrition, SUN Movement, <https://reliefweb.int/report/world/new-data-driven-tool-shows-promise-strengthen-multisectoral-nutrition-investments-better-nutrition>, Accessed: 28 August 2023.

59 IDA’s New Fundraising Campaign: An Early Test for World Bank President Banga, Center for Global Development, 2023, <https://www.cgdev.org/blog/idas-new-fundraising-campaign-early-test-world-bank-president-banga>, Accessed: 28 August 2023.

60 IDA20 Replenishment, World Bank, <https://ida.worldbank.org/en/replenishments/ida20-replenishment/ida20>, Accessed: 28 August 2023.

Many global financing structures are also being set up to tackle climate change. One such example is the Green Climate Fund. Similarly to IDA, the Green Climate Fund has key thematic areas, one of which is health, food and water security.⁶¹ Given that rapidly increasing climate change poses a rising threat to mental health and psychosocial wellbeing, these issues are strongly linked and must therefore be tackled together.⁶² The Green Climate Fund has recently agreed its strategic plan for 2024–2027, with annual reviews on implementation.⁶³

INNOVATIVE FINANCE MECHANISMS

There are many innovative financing mechanisms which could prove effective with respect to the current financing situation outlined in this report. One example is blended finance,⁶⁴ which is becoming more commonplace in development. Growing at a rate of around 20% per year, it will likely impact the mental health financing landscape as well.⁶⁵ Social impact bonds (SIBs) are a type of blended finance, first introduced in the UK in 2010. Their aim is to allow governments to access new sources of capital to address social problems not sufficiently funded by public investment.⁶⁶

Results- or outcomes-based financing is when funding is released based on the attainment of certain outcomes – for example, a jobseeker finding employment or a child returning to school and attaining better grades. Many development agencies have begun to link development assistance to results to increase the efficiency and effectiveness of aid programmes. This method has been used to incentivise many different actors and institutions, particularly within the education sector.⁶⁷ The literature suggests conditional cash transfers to students and families reduces dropout rates and increases attendance and completion rates.

61 Green Climate Fund themes & results areas, Green Climate Fund, <https://www.greenclimate.fund/themes-result-areas>, Accessed: 28 August 2023.

62 Why mental health is a priority for action on climate change, World Health Organisation, 2022, <https://www.who.int/news/item/03-06-2022-why-mental-health-is-a-priority-for-action-on-climate-change>, Accessed: 28 August 2023.

63 Green Climate Fund – Strategic Plan 2024-2027 Proposal, Green Climate Fund, 2023, <https://www.greenclimate.fund/sites/default/files/document/gcf-b36-17-rev01.pdf>, Accessed: 28 August 2023.

64 Blended finance is the practice of combining official development assistance with other private or public resources, in order to ‘leverage’ additional funds from other actors (Pereira J. Blended Finance: What it is, how it works and how it is used, 2017).

65 Development Initiatives, Blended finance: Understanding its potential for Agenda 2030, 2016, <https://devinit.org/resources/blended-finance-understanding-its-potential/>.

66 Katz AS, Brisbois B, Zerger S, Hwang SW. Social Impact Bonds as a Funding Method for Health and Social Programs: Potential Areas of Concern. *Am J Public Health*. 2018. doi: 10.2105/AJPH.2017.304157.

67 Results-Based Financing (RBF) and Results in Education for All Children (REACH), World Bank, <https://www.worldbank.org/en/programs/reach>, Accessed: 28 August 2023.

It is not just development actors who have used incentive- and results-based financing. In the 1990s, the Mexican government launched a programme called PROGRESA aimed at developing the human capital of poor households.⁶⁸ Drawing on finance equivalent to 0.2% of the country’s GDP, it distributed cash conditionally to families, covering around 2.6 million families (40% of all rural families). Initial analysis of the impact of PROGRESA suggested children received, on average, 0.7 years of extra schooling.^{69,70}

The [Healthy Brains Global Initiative](#) is an outcomes-based model that supports bottom-up approaches to improve mental health and foster systems-level change. The idea behind the initiative is to maximise impact and let donors see the results produced by their money. This organisation is young and concrete results are yet to be seen. However, there are two programmes already using impact bonds, funded by a mixture of development actors and social investors. The first focuses on getting young people in the occupied Palestinian territories into sustainable employment. The initial value of the development impact bond inputted from investors was US\$6.25 million and it is set to have an extension of US\$6 million over the next three years. The second supports refugees in the UK to move from temporary to permanent accommodation, access essential services and to participate in training or employment.⁷¹

68 Human capital is defined by the World Bank as consisting “of the knowledge, skills, and health that people invest in and accumulate throughout their lives, enabling them to realize their potential as productive members of society”. <https://www.worldbank.org/en/publication/human-capital/brief/the-human-capital-project-frequently-asked-questions#HCP2>

69 PROGRESA and its impacts on the welfare of rural households in Mexico, IFPRI, <https://www.ifpri.org/publication/progres-a-and-its-impacts-welfare-rural-households-mexico>.

70 Student Incentives, World Bank, <https://www.worldbank.org/en/programs/reach/brief/student-incentives>, Accessed: 28 August 2023.

71 Healthy Brains Global Initiative: Activities & Priorities, <https://www.hbgi.org/current-activities-and-priorities>, Accessed: 28 August 2023.



CONCLUSION

Domestic spending on mental health is low: the global median of public spending on mental health in 2020 was just 2.1% of government health expenditure. This is far behind the Lancet Commission's target of at least 5% in LMICs, and 10% in HICs. Consequently, there is a gap at the domestic level of over US\$200 billion, with LICs requiring an additional US\$200 million and lower-middle-income countries an additional US\$3 billion. Data is only available for both 2017 and 2020 in 54 WHO member states and, where it exists, there is no evidence that the proportions of funding are increasing.

External actors – including development actors and private organisations – fill some of this financing gap. Philanthropic and bilateral development organisations together provided over US\$200 million of development assistance for mental health (DAMH) in 2021. Most of this was channelled to LICs and LMICs, making up a quarter of the financing gap in LICs and a much smaller proportion in LMICs. There is limited data on private financing volumes, but there is evidence of foreign direct and indirect investment in mental health, as well as corporate social responsibility activities to improve the mental wellbeing of employees.

It is clear, then, that changes are required in how mental health is financed. Governments – particularly those of high-income countries – are not spending enough on mental health, and they are generally far from reaching the targets set out in the Lancet Commission report. Furthermore, external actors (e.g. development actors and the private sector) spend very little on mental health compared to other types of healthcare. If all development actors reporting to the OECD DAC increased the proportion of development assistance for health (DAH) going to mental healthcare to 1%, there would be an extra US\$446 million available worldwide.

In addition to simply increasing the size of mental health financing, it is vital the money is spent in the most efficient and effective manner. Both government and development actors have opportunities to mainstream their mental health treatment across sectors, particularly in the implementation of universal health coverage. There are considerable benefits when mental health is not treated in silo but in combination with its comorbidities. While cross-sectoral spending on mental health is encouraged among development actors, there is currently no system for quantifying this spend, whereas other issues, such as nutrition, already have a marker system.

There are also opportunities to leverage funding in global financing partnerships such as the Global Financing Facility, the Global Partnership for Education, the International Development Association (IDA) and the Green Climate Fund. Since rapidly increasing climate change poses a rising threat to mental health and psychosocial wellbeing, there is a benefit in tackling and financing these issues in tandem. Innovative finance mechanisms such as blended finance and results-based financing also have the potential to leverage other sources of finance from the private sector and other public sources.

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