Table of Contents

1 EXECUTIVE SUMMARY ........................................................................................................... 6

2 INTRODUCTION ................................................................................................................... 10

2.1 STRATEGIC SETTING ........................................................................................................ 10

2.2 AIM OF THE PAPER .......................................................................................................... 10

3 CURRENT SITUATION/CONTEXT .......................................................................................... 12

3.1 THE CHALLENGE .............................................................................................................. 12

3.2 THE TREATMENT GAP ....................................................................................................... 13

3.3 THE IMPACT ..................................................................................................................... 13

3.4 THE OPPORTUNITY ........................................................................................................... 15

3.5 FINDINGS FROM PHASE 1 ............................................................................................. 16

4 MENTAL HEALTH EXTERNAL FINANCING LANDSCAPE .................................................. 19

4.1 OVERVIEW ........................................................................................................................ 19

4.2 CURRENT MENTAL HEALTH FUNDING SOURCES ...................................................... 20

4.3 QUANTUM AND TYPE OF FUNDING NEEDED FOR MENTAL HEALTH ..................... 23

4.4 CONCLUSIONS ................................................................................................................ 30

5 OPTIONS TO INCREASE GMH FINANCING ......................................................................... 31

5.1 HOW TO THINK ABOUT FINANCING GLOBAL MENTAL HEALTH ............................. 31

5.2 SOURCING ADDITIONAL FUNDING FROM OTHER ‘ENTRY POINTS’ ........................... 33

5.3 MOBILISING DOMESTIC RESOURCES ............................................................................ 35

5.4 FUNDING PROFILE FOR INTERVENTIONS ..................................................................... 36

5.5 MATCHING INTERVENTIONS WITH ACTION PACKAGES ........................................... 37

5.6 CONCLUSIONS ................................................................................................................ 38

6 OPTIONS FOR FINANCING MECHANISMS ....................................................................... 39

6.1 AN IFF FOR MENTAL HEALTH ....................................................................................... 39

6.2 MENTAL HEALTH CAPITAL ACCOUNT ....................................................................... 41

6.3 MENTAL HEALTH GUARANTEE FACILITY ................................................................ 43

6.4 GIVING PLEDGE .............................................................................................................. 45

6.5 FINANCING MECHANISMS: OPTIONS SUMMARY ......................................................... 47

6.6 CONCLUSIONS ................................................................................................................ 47

7 STRUCTURAL OPTIONS FOR GMH FINANCING ................................................................ 48

7.1 ENGAGEMENT PRINCIPLES ............................................................................................ 49

7.2 HOSTING OPTIONS .......................................................................................................... 50

7.3 CONCLUSIONS ................................................................................................................ 53

8 PROPOSED PLAN .................................................................................................................. 54

8.1 RECOMMENDED APPROACH ......................................................................................... 54

8.2 NEXT STEPS ...................................................................................................................... 56

9 CONTRIBUTORS....................................................................................................................... 57
List of Tables

**TABLE 1: PHASE 1 ACTION PACKAGES AND COUNTRY GROUPS** ................................................................. 17
**TABLE 2: MENTAL HEALTH TREATMENT PACKAGES FOR EACH SPENDING LEVEL** .............................................. 25
**TABLE 3: ILLUSTRATIVE MENTAL HEALTH 10-YEAR FUNDING PROFILE ACROSS LMICS** ........................................... 27
**TABLE 4: ILLUSTRATIVE 10-YEAR SPENDING PROFILES IN LMICS (US$ MILLIONS)** .................................................. 28
**TABLE 5: MENTAL HEALTH ENTRY POINT OPPORTUNITIES** .................................................................................. 34
**TABLE 6: COMPARISON OF FINANCING MECHANISMS** ......................................................................................... 47
**TABLE 7: ILLUSTRATIVE MATCHING OF ACTION PACKAGES AND FINANCING MECHANISMS** ........................................ 48

List of Figures

**FIGURE 1: ILLUSTRATIVE PROFILE OF ACTION PACKAGES AND COUNTRY GROUPS** .................................................. 18
**FIGURE 2: DAH BY HEALTH FOCUS 1995-2015** .......................................................................................................... 20
**FIGURE 3: FLOW OF DAMH 2000-2015** ....................................................................................................................... 21
**FIGURE 4: PHILANTHROPIC GIVING BY SECTOR 2013-15** ........................................................................................... 23
**FIGURE 5: ILLUSTRATIVE SUSTAINABILITY MODEL FOR LMIC MENTAL HEALTH ECOSYSTEM** ................................... 30
**FIGURE 6: ILLUSTRATIVE 10-YEAR FUNDING PROFILE FOR MENTAL HEALTH INTERVENTIONS** ........................................ 37
**FIGURE 7: WHERE DONORS FUND RECIPIENTS** ............................................................................................................ 41
**FIGURE 8: WHERE RECIPIENT GOVERNMENTS USE THE FACILITY TO FRONTLOAD FUNDS AT LOW COST** .................... 41
**FIGURE 9: MENTAL HEALTH CAPITAL ACCOUNT STRUCTURE** .................................................................................... 43
Terminology

This report uses a variety of terms that have several working definitions, so it is important to clarify these from the outset. The terms ‘mental health’, ‘mental illness’ and ‘mental, neurological and substance use disorders’ (MNS disorders) are used regularly.

‘Mental health’ is ‘a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community’. We use the term in this way, to mean health and wellbeing, inclusive of social determinants and respecting human rights.

‘Mental illness or mental health problems’ refer to suffering, disability or morbidity due to mental, neurological and substance use disorders, which can arise due to the genetic, biological and psychological make-up of individuals as well as adverse social or environment factors e.g. autism, intellectual disability and ADHD in childhood, to mood, trauma related and anxiety disorders, alcohol and drug use disorders, schizophrenia and bipolar disorder and self-harm in adolescents and adults, to dementia in older people.

The term ‘mental health worker’ refers to those working towards attaining broader improved experiences of mental health across a variety of conditions and MNS disorders. We defer to the WHO definition, which states that mental health workers possess some training in health or mental health care, but do not fit into any of the defined professional categories (e.g. medical doctors, nurses, psychologists, social workers, occupational therapists).

‘Stigma’ is ‘the phenomenon whereby an individual with an attribute which is deeply discredited by his/her society is rejected as a result of the attribute (Goffman, 1963). The term ‘stigma’ refers to problems of knowledge (ignorance), attitudes (prejudice) and associated behaviour (discrimination and social exclusion)’. Stigma reduction activities are referred to in this paper as ‘increased mental health public awareness’ as distinct from ‘advocacy’ which refers specifically to making the case to decision makers for greater political and financial support for tackling mental health issues.

The term ‘global mental health’ is used here to mean the area for evidence, policy, financing and practice that places a priority on improving mental health and achieving equity in health for all people worldwide. This paper is focussed on the response to inequities in mental health, in LMICs, while acknowledging that higher-income countries (HICs) also have inequities and have much to contribute towards, and benefit from, mutual learning between LMICs and HICs.

Low and middle income countries (LMICs) assumes the 2018 World Bank country categorisation (countries with less than US$1,035 GNI per capita are classified as low-income economies, between US$1,036 and US$4,085 as lower middle income economies, between US$4,086 and US$12,615 as upper middle income economies, and more than US$12,615 as high-income economies). This paper defines LMICs as low- and lower-middle income economies only, not upper-middle income economies.

Innovative Finance refers to a range of approaches to mobilise resources and improve the efficiency of funding flows. Financing mechanisms are ways in which financial resources are made available (e.g. front-loading grant commitments, voluntary consumer-based funding; redirecting debt, regulation-based funding i.e. levies and taxes).

Civil society is the “third sector” of society, distinct from government and business, that manifests the interests and will of citizens. It refers to the space for collective action around shared interests, purposes and values, generally distinct from government and commercial for-profit actors.
Acronyms

BCG  The Boston Consulting Group
BMGF  Bill and Melinda Gates Foundation
DAH  Development Assistance for Health
DAMH  Development Assistance for Mental Health
DALY  Disability-Adjusted Life Year
DCA  Development Credit Authority
IFC  International Finance Corporation
IFF  International Financing Facility
IFFIm  International Financing Facility for Immunisation
GCFMH  Global Campaign for Mental Health
GFATM  Global Fund to Fight AIDS, Tuberculosis and Malaria
FIF  Financial Intermediary Fund
LHGP  Lions Head Global Partners
LMICs  Low- and lower-middle income countries
MDBs  Multinational Development Banks
MDF  Multi-donor fund
MDGs  Millennium Development Goals
MNS  Mental, neurological and substance use
NCDs  Non-Communicable Diseases
OPIC  Overseas Private Investment Corporation
PRIME  Programme for Improving Mental Health Care
SDGs  Sustainable Development Goals
UHC  Universal Health Coverage
UN  United Nations
UNRWA  United Nations Relief and Works Agency for Palestine Refugees in the Near East
UK  United Kingdom
US  United States
USAID  United States Agency for International Development
SIDA  Swedish International Development Cooperation
WHO  World Health Organisation
WBG  World Bank Group
1 EXECUTIVE SUMMARY

Mental disorders affect one in four of us over a lifetime. They represent a huge cost to our health care systems and to the global economy, and affect some of the world’s most vulnerable people. Despite the huge burden, mental health receives a fraction of the funding allocated to other diseases, especially in LMICs where both the quantity and quality of available treatment is inadequate.

The WHO’s Mental Health Action Plan (MHAP) 2013-20 and Mental Health Gap Action Programme (mhGAP) set out clear priorities and targets for countries to deliver. In 2015 the world took a further, huge step forward by including mental health in the Sustainable Development Goals (SDGs), which set the global agenda for the next 15 years. Given the current trends in health and mental health financing, the scale and ambition of the MHAP and the SDGs and the aspiration towards Universal Health Coverage (UHC), existing levels of funding and traditional financing means will not be sufficient to achieve meaningful change. However, this is not just a health sector issue, and targeted action will be required from multiple stakeholders, working collaboratively across sectors, to solve what is a major inter-sectoral and broader development challenge.

There are important lessons to be learned from the delivery of integrated mental health services at the community level and growing evidence of success in existing in-country efforts; strong momentum has been created in some areas, and in some countries. But only ~0.5% of low-income countries’ annual health budgets is allocated to mental health, of which 80% goes to mental hospitals, and in 2015 development aid to mental health (DAMH) was US$132 million, equating to just 0.4% of total development aid to health (DAH). More can and should be done. If progress is to be made across the globe at the required scale, we need to prioritise mental health funding as a matter of urgency.

Consultations have revealed that some global mental health constituents support a new financing mechanism(s) to source and accelerate non-traditional funding for mental health, whilst others posit that any growth in mental health funding, at least in the short term, is likely to be derived from leveraging existing development commitments and other ‘entry point’ opportunities, instead of ‘new’ resources. Whilst mindful of the competing demands for international funding for health and other development sectors, this paper concludes that leveraging existing channels (including mobilising a greater proportion of domestic resources apportioned to mental health), and the creation of one or more ‘new’ financing mechanism(s), will be required to secure the quantum of funding needed to accelerate action on global mental health at the scale of ambition set out in the SDGs and the forthcoming Lancet Commission report, and to scale up sustainable, country-led interventions over the longer term.

The paper outlines options for financing mechanism(s) to increase funding for integrated global mental health service delivery in LMICs in the mid- to long-term, and proposes a practical plan for implementation. It focuses on how to generate additional funds from donors (governments, multi-lateral organisations, trusts and foundations, international NGOs, philanthropists and other ‘entry points’ etc) for governments, organisations and institutions conducting activities in global mental health in LMICs. It does not make proposals around disbursement, which is a different set of instruments, and should only be taken forward after detailed donor and country-level consultations. It does not advocate the need for a new vertical structure, recognising the strong merit in an inter-sectoral approach to mental health, integrated into country-led national plans, to best achieve the SDGs.

Consensus around what to fund is growing, as is the evidence base of ‘what works’ and the range of interventions recommended for scale up. Agreement is now needed on where funding should be
deployed, and for how many people, as is reaching consensus on the aim, parameters and funding baseline of any new financing initiative. An ambitious and achievable illustrative aim is: “To deliver life-saving and life-enhancing mental health services to over 1 billion of the world’s most vulnerable people, in many of the world’s poorest countries, over the next 10 years, multiplying the current spend on global mental health in low-and lower-middle income countries (LMICs) by a factor of 15”. This would require an increase in the average spend on mental health in LMICs from US$0.2 to US$3.00 per head of population, per year, by 2030. An incremental approach to this target would cost US$19 billion over 10 years, or an average of US$1.9 billion p.a.

This is a sizeable goal, and achieving a catalytic step-up in funding to realise it will require a multi-layered approach, and a full exploration of existing, traditional and alternative funding sources. The global health sector has already looked to new ways of raising finance. For example, the Global Financing Facility (GFF) uses grants from its trust fund to leverage more investment from domestic government resources, the WBG, aligned external financing and the private sector. Similarly, the International Financing Facility for Immunisation (IFFIm) has mobilised more than US$5 billion for Gavi, the Vaccine Alliance, through long-term pledges from donor governments to sell ‘vaccine bonds’ in the capital markets. The global health sector already has channels through which funds for mental health are raised and spent. During the drafting of this paper a new proposal to establish a Multi-Donor Trust Fund to provide catalytic support to NCDs was announced, demonstrating the importance of avoiding duplication and overlap with parallel initiatives, or simply taking money from one development issue to give to another.

The global mental health community has been grappling for some time with how best to significantly increase funding for the sector. Led by the WHO and WBG, with the substantial input of others, efforts have been made to identify financing mechanisms or instruments that could support a scale-up in global mental health funding. Building on that work, and in accordance with the Addis Ababa Action Agenda on Finance for Development, this paper outlines four financing mechanisms, and four hosting options, that could provide the required quantum and profile of funding to achieve an average US$1.9 billion p.a. towards mental health in LMICs over the next 10 years, primarily to improve overall mental health systems to enable the delivery of effective and sustainable services, and reduce the disease burden.

The following four mechanisms are not the only financing options, nor are they mutually exclusive, but those assessed to have the best chance of success at this stage given what we know, and without simply ‘taking money’ from one development issue to another:

- A mental health **International Financing Facility** to generate a critical mass of predictable finance from donors to help LMICs make long-term budget and planning decisions on critical mental health implementation programmes (including training and infrastructure).

- A mental health **Capital Account** taking an endowment approach to securing long term, sustainable funding from donors for predictable low-level mental health programmatic needs in LMICs (e.g. advocacy, policy development, legislation) over the life of the mechanism.

- A mental health **Guarantee Facility** to expand the scope of LMICs to access additional MDB concessional loans above their borrower limit, conditional that the additional funding would be spent on mental health projects or systems.

- A mental health **Giving Pledge** which could attract a wider, new generation of philanthropists, corporations, trusts and smaller bilateral donors to pool resources for one-off mental health crises, innovations or projects requiring early stage or catalytic capital outlays.
The following hosting options are also outlined in the paper:

- Hosted Entity: Trust Fund or Financial Intermediary Fund (FIF) hosted by the World Bank
- Separate Entity: Own board hosted under United Nations Office for Project Services (UNOPS)
- Hosted Entity: Under a university or Research Institute
- Stand-alone entity: A New Financing Institution

This paper has been produced within a tight timeline and budget. Much of the analysis has only been able to go ‘so far’, and the next phase of the work will examine financing mechanisms in more detail including individual or collective viability and prioritisation, connections to various ‘entry points’ and development sectors, and a more detailed design and in-country implementation assessment. There is considerable further work to be done to test the suitability, practicality and technical facets of each, and whether donors, foundations, trusts, the private sector and philanthropists concur with the analysis. Most critically, for any of the mechanism(s) to succeed, the financing and implementation plans have to be integrated, country-led, and respond to country-level priorities, recognising that LMICs are already making trade-off decisions between competing funding priorities.

This paper has sought to summarise, based on the expertise of the mental health community, the following:

1. The unique financing needs of the global mental health challenge the world faces.
2. The globally agreed goals the global mental health community wants to achieve.
3. In broad terms the quantum of funding that needs to be raised each year for global mental health to achieve those aims.
4. The countries and populations that should be prioritised for scaled up mental health service delivery to achieve maximum catalytic impact.
5. That insufficient funding can be generated for global mental health through existing development commitments, and other, existing ‘entry point’ opportunities.
6. Examples of additional ‘new’ forms and sources of funding required beyond leveraging existing development commitments, other ‘entry point’ opportunities and domestic resource mobilisation.

Based on this analysis, some decisions need to be taken with potential donors and national actors, supported by experts in mental health, to establish how best to increase funding for mental health:

1. What are the most effective and catalytic mechanisms that should be developed further to deliver the quantum of financing required and what is the timeline to do so (‘Phase 3’).
2. How can the global mental health community use events such as the launch and roll out of the 2018 Lancet Commission on Global Mental Health and Sustainable Development, to persuade domestic and international policy makers to invest more in mental health.

The forthcoming Lancet Commission report, which synthesizes the science and experiences of the past decade, will offer a fresh perspective on the actions needed to reduce the global burden of mental and substance use disorders. Building on this, there is a clear opportunity over the next 6 months to galvanise a united sector response to the global mental health challenge, the opportunity and agree potential solutions to the funding and treatment gaps. This provides an historic platform for securing the commitments required to complete the next phase of this work.
2 INTRODUCTION

2.1 Strategic Setting

Poor mental health is the leading cause of years lived with disabilities around the world and the third leading contributor to the global burden of disease\(^\text{14}\). One in four people in the world will be affected by mental or neurological disorders at some point in their lives\(^\text{15}\). Mental health problems are a truly global/universal issue with the potential to affect anyone, anywhere, across the world. They carry a huge cost to our health care systems and to the global economy, and disproportionally affect some of the world’s most vulnerable people.

Yet global mental health is severely underfunded, receiving a fraction of the funding of other health agendas, and the funding it does receive is frequently fragmented (delivered through a myriad of small projects rather than focussing on systemic change and universal service provision). This leaves millions of people without or with inadequate treatment. Up to nine out of ten people with a mental health problem do not receive even basic care in some countries\(^\text{16}\). There is a significant unmet need, with the largest funding and treatment gaps in LMICs, who shoulder a disproportionate impact.

The huge funding and treatment gap is due to a range of factors ranging from the low priority accorded to mental health by governments, the stigma attached to mental health, poor understanding of the impact of mental health problems and how to treat them effectively, barriers within local health systems, mal-coordinated global policies, and insufficient financial and human resources\(^\text{17}\). WHO reports that according to 2015 figures, mental health expenditure was less than 0.5% of total development health expenditure\(^\text{18}\).

In 2015 mental health was put firmly on the global agenda with its inclusion in the Sustainable Development Agenda, world leaders recognising mental health and well-being as a health priority. The WHO MHAP 2013-20 sets out clear priorities and targets for countries to deliver\(^\text{19}\). However, even countries with stand-alone mental health plans or strategies (72% of WHO Member States)\(^\text{20}\), are failing to turn them into costed and funded initiatives, and human and financial resources allocated for implementation remain limited. This means important targets such as a 20% increase in service coverage for severe mental disorders by 2020 is in danger of not being met\(^\text{21}\). There is an urgent need to scale up mental health services worldwide, and particularly for the most underserved populations.

2.2 Aim of the Paper

2.2.1 Background

In April 2016, the WBG and WHO co-hosted a meeting at which making mental health a development and funding priority, was widely agreed as necessary to deliver greater action on mental health, especially in LICs and MICs\(^\text{22}\). In September 2017, senior mental health advisors met and agreed that improved advocacy and increased financing for global mental health was needed. The Global Campaign for Mental Health (GCFMH) was formally established in January 2018 to try and address this gap. A meeting of stakeholders at the WBG on 28 February 2018 (“Healthy Brain Bonds; Is this a feasible option”) agreed that increased financing along the continuum of mental health interventions was needed, and a ‘menu’ of different instruments to support this range of interventions would be developed as one of two work streams (research and service delivery), but with a unified vision to capitalise on synergies.

On the service delivery stream, it was agreed that the GCFMH would lead a working group tasked with reviewing options to increase funds for scaling-up the integrated delivery of mental health
services in LMICs, including across different sectoral ‘entry points’. The GCFMH had already designed three phases to this work:

Phase 1 – what to fund and where

Phase 2 – menu of financing mechanism(s)

Phase 3 – development of one or more financing mechanism(s) for implementation (and action to accelerate an increase in funding through existing channels)

GCFMH commenced Phase 1 of this work and secured The Boston Consulting Group (BCG) to submit answers to the question “what needs to be funded and where”? BCG’s Phase 1 report, based on inputs from the working group, developed a programmatic focus of potential new funding for global mental health, using the priorities of the MHAP 2013-20 as a starting point. It developed ‘interventions’ (scalable action packages), and country groups (based on characteristics such as political will), to scope what increased mental health funding could finance in LMICs to achieve catalytic effect.

On behalf of the working group, Lions Head Global Partners (LHGP) took forward Phase 2 (this paper), to develop a menu of financing mechanisms to support fundraising for global mental health services, conducted alongside a wider consultation with the mental health academic and implementation community. The purpose of Phase 2 was not to be exhaustive or prescriptive, but rather to outline options for generating additional funding to mental health to support a range of interventions, and the engagement of a broad number of potential stakeholders, including donors.

Phase 3 of this work will be to develop the proposals for the best means to accelerate funding into practical action. The GCFMH intends to commission this work based on the discussion of the conclusions of Phase 2.

It is outside the scope of the paper to make recommendations on which organisation(s) manages and disburses the funds generated. This will be up to health policy makers, the mental health community and current and potential funders to determine. It could be an existing organisation such as the WHO, UNDP or WBG, or a new organisation set up with different governance structure; for simplicity this paper refers to MH.org as the financing mechanism(s). It will need to be hosted and potential hosting agencies (and thus disbursement mechanisms) are also included.

This paper was funded by GCFMH but the conclusions are independent. The paper makes no assumptions about the role of GCFMH in the implementation of the recommendations of the report.

2.2.2 Aim

The aim of the paper is to outline options for financing mechanism(s) to increase funding for global mental health service delivery in LMICs, and propose a practical plan for implementation.

The term ‘financing mechanism’ can mean different things to different stakeholders. This proposal will focus on a financing instrument/mechanism(s) to generate additional funds for organisations and institutions conducting activities in global mental health in LMICs (i.e. fundraising). It will not make proposals around disbursement, which is a different set of instruments. It will not refer to an organisation but to a process through which funds are generated. The mechanism(s) will primarily focus on generating funds from donors (governments, multi-lateral organisations, trusts and foundations, international NGOs, the private sector and philanthropists) but recognise the importance of domestic resource mobilisation for country groups requiring development assistance, as well as those in crisis. It will reflect different ‘entry points’ and opportunities for co-operative/collaborative fundraising across sectors. Country-level consultations, whilst a vital part of the process, will happen at a later stage of the process to avoid building expectations prior to concrete funding proposals.
This is not a stand-alone paper, but part of a process and wider consultation with the whole global mental health community. It aims to accelerate the process of moving the global mental health community closer to having an actionable funded plan. It is not written by mental health experts, does not purport to be an academic or formal research paper, and is not for public release. It is a synthesis of research previously conducted in this field and analyses both existing and new funders and financing instruments. It is not trying to ‘re-invent the wheel’, nor does it promise a ‘silver bullet’ to close the treatment gaps in mental health, and is not intended in any way to denude from the outstanding work and initiatives already being employed in the mental health field. It is focused on service delivery, not to detract from interventions to specifically reduce stigma (e.g. amongst health workers), prevention, leadership and governance, or the essential need to tackle these areas more widely, but simply in order to help focus the scope of the financing options provided.

2.2.3 Consultation Process

Within the time available the consultation process has been as inclusive as possible to leverage the huge depth of knowledge and experience in the mental health field, although inadvertent omissions may have been made. The consultation process consisted of desk-based research, written questions and telephone interviews with working group members from 31st May to 21st June to prepare the paper’s first outline and draft. The paper was circulated for comment from 21st to 28th June, with further telephone interviews followed by a face-to-face meeting at end of July to discuss the draft paper. See Annex A for a list of contributors.

3 Current Situation/Context

3.1 The Challenge

The WHO estimates that globally one out of every four people will be impacted by poor mental health or mental illness at some point in their lives, imposing an enormous global disease burden that leads to premature mortality and affects functioning and quality of life, impacting not only on individuals, but also their families, carers, friends, and communities. Depression is ranked by WHO as the single largest contributor to global disability (7.5% of all years lived with disability in 2015); anxiety disorders are ranked 6th (3.4%).

Depression is also the major contributor to suicide deaths, which number close to 800,000 per year, and many more attempt suicide. Suicide is the second leading cause of death among 15-29 year olds globally, 78% of them in LMICs, and is the leading cause of death for young women (15-19 years). Worldwide, around 10% of expectant and 13% of new mothers experience a mental health disorder, but in developing countries those figures increase to 16% and 20% respectively. Many mental illnesses start amongst youth, and have a chronic, relapsing course, with over 75% showing by age 24. The prevalence of mental disorders, stigma and lack of awareness, and non-existent or insufficient treatment drive immense productivity losses for employers, as well as significant healthcare costs. It is an issue that crosses sectoral boundaries and will require a collaborative inter-sector response.

Mental health is also a development issue. It is a global challenge that disproportionally affects the most vulnerable members of society (e.g. the poor, young people, refugees, women and girls), and lack of attention to mental ill health will hamper the achievement of the Sustainable Development Goals (SDGs) due to the negative impact of mental health on a range of sectors beyond health. The focussed integration of mental health into Universal Health Care (UHC) could mitigate against these negative impacts.

Mental disorders are a leading cause of the global burden of disease, affecting millions daily, with severe social, economic and health impacts. The burden is large, growing and overlooked. A
disproportionate burden falls in LMICs where 3 out of 4 people with mental health problems live, and where the provision of mental health services remains very limited (1 in 10 people with mental disorders in LMICs receive treatment)\textsuperscript{31}. That is where the need is greatest, and resources fewest.

3.2 The Treatment Gap

The mental health 'treatment gap' refers to the proportion of individuals with mental health problems in need of treatment, but who do not receive it. In most countries the response to the mental health challenge is grossly inadequate. Millions of people suffering from mental illness do not seek help due to stigma and lack of available services. Around 90% of people with severe mental disorders in LMICs receive no treatment, and the quality of treatment available is poor\textsuperscript{32}. For example, minimally effective treatment rates (METS) in LMICs are very low for depression (3.7%), anxiety (2.3%) and substance-use disorders (1.0%)\textsuperscript{33}. The treatment gap for community oriented psychosocial interventions is virtually 100% for over 80% of the global population, and 100% of the LIC population\textsuperscript{34}.

Proven solutions to most of these challenges exist\textsuperscript{35}, yet most people do not get the help they need, with gross inequalities in mental health outcomes between and within nations. The most striking inequity concerns the disparity between the provision of care to people living with mental disorders between low-income and high-income countries. LMICs are home to over 80% of the global population yet hold less than 20% of the mental health resources\textsuperscript{36}. The main challenges to closing the treatment gap in low-income countries include stigma and lack of awareness, limited human and material resources, care delivered in institutional not community settings, and strategies not tailored to meet local population needs\textsuperscript{37}.

The consequent 'treatment gap' is vast. Serious mental illness remains a major public health challenge yet across the globe, annual mental health spending remains on average US$2.5 per person per annum (pppa)\textsuperscript{38}. More than 75% of those identified with serious anxiety, mood, impulse control or substance use disorders in the World Mental Health surveys in LMICs received no care at all. The arguments for providing access to treatment for mental health conditions in LMICs are well rehearsed yet resources are scarce, with mental health being allocated less than 1% of government health spending in most LMICs\textsuperscript{39}. Fewer than 1 in 5 get any treatment, and on average, patients who have a first episode of psychosis are likely to remain untreated for more than two years. As economies, ages and populations in LMICs grow, the growth in the burden of mental health will increase.

Even when treatment is provided, the quality often falls below what would be considered as the minimum acceptable standards. In many LMICs there is an over-reliance on mental health hospitals that absorb the majority (~80%) of government's mental health budgets\textsuperscript{40}. In well documented cases, human rights abuses such as unauthorised and unmonitored detention, shackling and chaining continue today in such institutions. Meanwhile the WHO is urging countries to update legislation, policies and plans in line with human rights instruments by 2020, but progress is too slow\textsuperscript{41}.

3.3 The Impact

3.3.1 Health Impact

Mental disorders, such as depression, anxiety, and substance use disorders, impose an enormous global disease burden that leads to premature mortality and affects functioning and quality of life. If left untreated, mental disorders can result in worse treatment adherence and outcomes for commonly co-occurring diseases, such as HIV, tuberculosis, diabetes, cardiovascular disease, and cancer.
People with mental disorders have higher exposure (and or prevalence) of key risk factors such as unhealthy diets, smoking, insufficient physical activity and harmful use of alcohol. Premature death associated with mental health disorders is high and suicide accounted for close to 1.5% of all deaths worldwide, making it the 15th leading cause of death. Effective and evidence-based interventions can be implemented at population, sub-population and individual levels to prevent suicide and suicide attempts. Even in high income countries (HICs), people with severe mental health problems die on average 20 years earlier than those without, largely due to poor treatment of physical health conditions.

### 3.3.2 Social Impact

Countries are not prepared to deal with this often “invisible” and often-ignored challenge. Despite its enormous social burden, mental disorders continue to be driven into the shadows by stigma, prejudice, or fear of disclosure because a job may be lost, social standing ruined, or simply because health and social support services are not available or are out of reach for the afflicted and their families.

Poor mental health impacts the most vulnerable in today’s societies, including the poor, women, youth, victims of conflict and refugees. Many endure discrimination and abuse and are prevented from exercising choice, pursuing opportunities and planning for the future. Poverty brings with it heightened stress, social exclusion, malnutrition, violence and trauma, all of which contribute to mental illness. It is a vicious cycle: people living with mental illness experience widespread stigma and discrimination, suffer violence and abuse, and find it harder to get work, get an education or contribute to their family and community. They are more prone to other forms of illness and disease and find it harder to access health care. The impact of poor mental health is felt by both individuals and their families with young people – including young parents or carers – among those hardest hit.

### 3.3.3 Economic Impact

In total poor mental health costs the world economy some US$2.5 trillion per year in reduced economic productivity and physical ill-health. This will rise to US$6 trillion by 2030 alongside social costs and the contribution to poverty, homelessness and crime. According to the World Economic Forum, mental illness will account for more than half of the economic burden of disease over the next two decades – more than cancer, diabetes, and chronic respiratory diseases combined.

Poor mental health also impacts on economic development through lost production and consumption opportunities at both the individual and societal level. Those age groups most affected by mental health, particularly suicide, are also those who are a crucial segment of the workforce in most countries. It is estimated that the lost economic output caused by untreated common mental disorders – depression and anxiety – as a result of diminished productivity at work, reduced labour participation, foregone tax receipts, and increased welfare payments amounts to over 10 billion days of lost work annually – equivalent to US$1 trillion per year. Yet studies have shown that for every US$1 invested on treating depression and anxiety (psycho social counselling and antidepressant drugs) there is a return of US$4 in terms of ability to work and better health and participation in the workforce.

### 3.3.4 Impact on achieving the SDGs

Inattention to mental health in countries will hamper their success in achieving specific health-related SDGs. It will also prevent progress toward achieving other SDGs.

Goal 3 of the SDGs focuses on ensuring healthy lives and promoting well-being for all; world leaders have committed to the “prevention and treatment of noncommunicable diseases, including behavioural, developmental and neurological disorders,” working towards the following SDG targets:
• **SDG 3.4** By 2030, reduce by one third premature mortality from NCDs through prevention and treatment, promote mental health and well-being (including indicator 3.4.2 on suicide rates).

• **SDG 3.5** Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol (including indicator 3.5.1 on coverage of treatment interventions for substance use disorders).

• **SDG 3.8** Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

Research over the last two decades, however, has made clear that the unmet burden of mental illness and distress is a serious impediment to the global development agenda. The WHO recently estimated that achieving SDG 3 as a whole will require investments to increase over time from an initial US$134 billion annually to US$371 billion by 2030. This figure would address the health challenges of just the 83 LMIC countries alone. Obviously no single government, civil society, or private sector can foot this bill. New mind-sets, technologies, models for collaboration, financing and delivery approaches will be needed to ensure all people receive the care that they need.

### 3.4 The Opportunity

Over the last 10 years, progress has been made on mental health, mostly in high income countries (especially UK, Canada, Australia), but also as a result of growing support from the WBG, WHO and UN, trusts and foundations, and countries such as Sri Lanka, Lebanon, Indonesia, Vietnam, South Africa, India, Brazil and Kenya prioritising mental health. Although much of the mental health burden is preventable, effective interventions for all types of mental illnesses have not been scaled up, and the ideal of achieving parity between mental and physical health conditions remains a remote target.

The WHO MHAP 2013-20 aims to scale up services for mental, neurological and substance use disorders for countries, especially LMICs, where a number of evidence-based, inter-sectoral strategies have been effective in promoting, protecting and restoring mental health. It asserts that with proper care, psychosocial assistance and medication, tens of millions could be treated for depression, schizophrenia, and epilepsy, prevented from suicide and begin to lead normal lives, even where resources are scarce.

There is growing momentum to move mental health from the periphery to the centre of the global health and development agenda. There is high potential, at least in the short term, to integrate mental health into other sectoral development programmes and ‘entry points’ to increase efficiency, cost effectiveness and speed to impact. Properly implemented interventions represent opportunities for significant returns in terms of health and economic gains. This is happening in parallel to the demographic changes at global and country level as policy makers grapple with rising numbers of young people (‘peak youth’) and – in some countries – a rapidly aging population.

As highlighted by the April 2016 World Bank-WHO meeting, strong leadership is needed to make mental health a priority, to integrate mental health services into general health services, to commit to innovative and quality service delivery, to channel resources toward mental health systems, to promote better coordination across platforms and sectors, and to strengthen community services. This will require additional resources from a range of sources, including development assistance, donor and domestic health budgets, directed towards implementing community-based mental-health
programmes, and strengthening the overall treatment of mental disorders as part of realising universal health coverage.

3.5 Findings From Phase 1

3.5.1 Overview

The overwhelming message from the mental health community was to base the project as much as possible on agreed evidence of ‘what works’. How to implement and scale up ‘what works’ in terms of service delivery formed the basis for Phase 1 work. BCG developed a programmatic focus of potential new funding for global mental health using the priorities of the WHO MHAP as a starting point and building on the work of the mental health community to date. Interventions were developed based on interview input and literature review (the ‘what’), countries grouped based on characteristics such as political will (the ‘where’) and a high-level view taken of the principles of implementation and evaluation (the ‘how’), to scope what new mental health funding can be utilised in LMICs to achieve catalytic effect. Importantly, it was assumed that any incremental funding mobilised would not exist in perpetuity, but rather would fund the most catalytic efforts to establish a strong global mental health ecosystem in LMICs by 2030.

3.5.2 Country Groups

The work focused on the practical implementation of existing evidence-based and scalable actions in LMICs by identifying country groups based on different countries’ start points towards mental health implementation ‘readiness’. In the first phase of work, countries were defined through four criteria:

- **Political will**: the level of government support to gauge what could practically be achieved.
- **Capacity**: absorption rates indicated by health leadership, advocacy and professional cadre.
- **Income level**: level of wealth and impact on the country’s external resource requirements.
- **Crisis level**: crisis countries require a different approach to address mental health conditions.

Five country groups were defined on the basis of the above: "Not yet open for change", "Proof of concept", "Open for change, needs technical and financing support", "Open for change, needs technical support", and "Crisis".

3.5.3 Action Packages

Country groups were then assigned action packages i.e. what would be the best means to support them, based on these criteria (see Table 1). Action packages were developed top-down, primarily using interviewee input and the WHO MHAP. Before activation, action packages would have to be adapted for a country’s culture, context, and specific ‘entry points’, developed in partnership with local authorities. The resulting customised action package might look very different to the generic ones created here for a low-income African country of ~40 million people. The realities of finding donors / financing might also impact the specifics of how action packages are deployed in particular countries. To ensure successful implementation, action packages would be developed based on evidence of ‘what works’, evaluated for effectiveness and cost-effectiveness, with indicators that could be clearly defined, measured and evaluated in a standardised way with the results used to improve future investments. Across action packages the ultimate long-term aim was system strengthening, e.g. to move countries from “not yet open for change” to levels of greater transformation ‘readiness’. 
### Table 1: Phase 1 Action Packages and Country Groups

<table>
<thead>
<tr>
<th>Action Package</th>
<th>Action Package description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Focus on advocacy</td>
<td>Influence government attitude to mental health, stimulate mental health leadership, “open the door” to further work</td>
</tr>
<tr>
<td>2. Demonstrations and pilots</td>
<td>Provide funds and expertise to run well-evaluated demonstration or proof of concept projects, and advocate for movement to scaled transformation</td>
</tr>
<tr>
<td>3. Health and community system transformation</td>
<td>Provide funds and expertise to transform mental health system development/reform</td>
</tr>
<tr>
<td>4. Focus on technical support</td>
<td>Provide technical expertise to accelerate transformation</td>
</tr>
<tr>
<td>5. Crisis</td>
<td>Provide emergency mental health aid as well as fund transformation and scaling of care. This often presents an opportunity to effect transformative change quickly.</td>
</tr>
<tr>
<td>6. Funding for innovation and cross-geography assets</td>
<td>Create assets that could be used in many countries; create central capacity; provide “accelerator”-type funding for promising projects</td>
</tr>
</tbody>
</table>

#### 3.5.4 Implementation and Evaluation

High-level principles for implementation and evaluation were also compiled, based on expert input.

- **Implementation** principles: the need for close involvement of governments and a strong role for civil society, especially ensuring the participation of people with lived experience of mental illness; investment into programmes that scale; integration of mental health into existing platforms; and running of continuous evaluation and monitoring for all actions.

- **Evaluation** principles included: the need to use outcome as well as process metrics; standardised evaluation methodology; running evaluation and monitoring throughout the duration of programmes; ensuring feedback loops for continuous improvement; and formal evaluations run by an external body.
3.5.5 Prioritisation of Funding (Illustrative)

It was agreed that potential additional funding should generate maximum direct impact (to show the ‘art of the possible’ in tackling mental health), as well as building momentum for change. With that in mind, impact would primarily be measured by sustainable delivery of effective services, uptake of services and service coverage, reduction of the disease burden and in creating a catalytic impact. Given that the scale up of mental health interventions is a challenge, especially where health systems are weak, it was agreed that the fastest route to impact would be to add a mental health component to existing programmes (e.g. within the pillars of UHC, healthy populations and emergency/crises)61. System strengthening should be a cross cutting theme if we really aim at sustainable impact.

Following this logic, Action packages 3 ("Health and Community System Transformation"), 4 ("Technical Support") and 5 ("Crisis") are directly impactful, ideally sustainable and catalytic, and therefore should be prioritised. Within them the key actions are those set in the community.

- **Action Package 3 (Health and Community System Transformation)** delivers services directly, with a focus on community and primary care, in a setting with a good probability of success; and will likely absorb the largest amount of funding (e.g. ~50% of funding).
- **Action Package 5 (Crisis)** also delivers services directly, but in a setting with higher need but lower feasibility of success vs Action Package 3; likely that this will absorb the second largest amount of funding as crisis locations are more expensive to operate in and have higher burdens of psychological stressors (e.g. ~25% of funding).
- **Action Package 4 (Technical Support)** is highly efficient, as it enables the delivery of services to a large extent using local funds, in a setting with a good probability of success; it should be prioritised (it is low-hanging fruit), but is likely to absorb less funds (e.g. ~10% of funding).

Within Action Packages 3 and 5, clinical and non-clinical community-based service delivery will be priorities. However, to deliver sustainable and appropriate care in these settings, an integrated set of actions (e.g. advocacy, clinical service delivery, improving health care facilities, mental health
awareness/promotion) would need to be implemented; the exact set of interventions would differ, and would be country-led and customised according to in-country priorities.

Action Packages “Focus on advocacy” and "Demonstrations and proof of concept" were assessed as less directly impactful, but nevertheless necessary to fund in order to move countries to the point of being able to implement transformation at scale (in that sense, they are “catalytic”), and may be suited to specific donors or financing packages.

- **Action Package 1 (Focus on advocacy)** is critical, but further away from delivering direct impact (e.g. ~5%).
- **Action Package 2 (Demonstrations or proof of concept projects)** is likely to be opportunistic and influenced by country-specific ‘entry points’ (e.g. ~5% of funding).
- **Action Package 6 (Innovation and cross-geography assets)** likely to be opportunistic, and would probably focus on smaller and relatively isolated, though impactful, projects (e.g. ~5%).

### 4 Mental Health External Financing Landscape

#### 4.1 Overview

The landscape of global mental health funding is complex with multiple stakeholders. The WHO Mental Health Atlas highlights the fact that in more than two-thirds of countries the care and treatment of persons with severe mental disorders is not included in national health insurance or reimbursement schemes. Only a little over half of the 162 countries responding to the WHO Mental Health Atlas survey reported that their mental health policy or plan contained estimates of financial resources to implement them. In LICs the median government mental health expenditure is at US$0.02 pppa; in lower middle-income countries it is US$1.05 pppa, with more than 80% of that going directly towards institutions such as mental hospitals[^62].

There is a huge financing gap in global mental health. A combination of bilateral, multilateral, philanthropic and miscellaneous private donors fill a relatively small portion of this gap, but it should be noted that a large percentage of those suffering from mental health disorders in LMICs are paying for services themselves; out-of-pocket payments for mental health treatment accounts for 40% of the total spend in Africa and 43% in South East Asia[^63]. Diverse funding sources go towards a diverse set of sectors that range from general health, to education, to crisis and humanitarian response. One of the fundamental challenges in relying on external funding, and seeking additional external funding for mental health is ensuring it is well coordinated. Equally important is the development of a comprehensive approach to financing mental health that ensures service delivery for all (as part of the overall goal of attaining UHC). A second challenge is that DAMH is far too low (0.4% of overall DAH), and most DAMH goes towards research not service delivery.
Compared to other sectors receiving Development Assistance for Health (DAH), mental health spending remains relatively low. In 2015, total DAH was estimated to be US$36 billion per annum, and out of this, US$110 million was allocated for mental health. While Development Assistance for Mental Health (DAMH) did experience a 6-fold increase (from US$18 million in 1995 to US$132 million in 2015), it still only accounted for 0.4% of total DAH. Geographically, South Asia has received the largest proportion of funding for mental health, and out of all World Bank regions it has also experienced the largest percentage increase in DAMH since 1995. This was followed by Sub-Saharan Africa, North Africa Middle East, East Asia and the Pacific, which received the smallest fraction of DAMH.

4.2 Current Mental Health Funding Sources

In terms of overall mental health spending, from 2000-2015 private philanthropy was the most significant single source of DAMH at US$435 million, accounting for one third of all DAMH. The US government came second, providing US$270 million of total DAMH. NGOs and foundations provided the overwhelming majority of DAMH (US$780 million or approximately two thirds of total DAMH) over the 2000–2015 period.

4.2.1 Bilateral Donors

The US, UK, Germany, France, Canada and Australia remain the top donor countries to DAMH over the past few years, although interestingly none have their own global mental health strategy. Funds are targeted towards a variety of programmes that vary according to donor interest and country needs. Bilateral DAMH has fluctuated over time. The largest bilateral donor (the US), in support of SDG 3, often funds mental health projects attached to other areas such as HIV/AIDS related programs, humanitarian assistance, national security programmes and education.

UK aid for mental health activities overseas includes programs covering humanitarian, education and crisis recovery activities. One example is support to the WHO for the Syria crisis, providing essential mental health and psychosocial support services to those who have been affected by the conflict, including therapy and medication. Another is the Jordan Compact Education Programme, making psychosocial support available to refugee children alongside providing access to education. DFID also funds the Programme for Improving Mental Health Care (PRIME), set to end April 2019, a programme of implementation research seeking to integrate packages of care for priority mental disorders in district health care programs in five LMICs.
Since the adoption of a domestic mental health strategy in 2012, Canada continues to champion mental health issues, and with their 2017 budget, proposes to invest CAD$5 billion over 10 years to support mental health initiatives in Canada and the provinces. Canada is one of the three founding members of the recently-formed Alliance of Champions for Mental Health and Wellbeing (with Australia and the UK) and continues to have a strong global presence through Grand Challenges Canada’s Global Mental Health Care Programme, which in 2011–17, invested CAD$42 million in 85 innovative research projects in 31 countries to improve treatments and expand access to care.

For Germany, strengthening psychosocial work is a common theme amongst mental health programmes, including the support of MHPSS work in Syria and in Jordan, providing psychosocial support training to United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) employees, for Palestinian refugees, as well as scaling up health services in Pakistan. During its 2017 G20 presidency, Germany demonstrated strong leadership on global health (similar to its G7 presidency in 2015) by including health on the G20 agenda for the first time. Mental health experts attended a special meeting on health ahead of the summit.

### 4.2.2 Multilateral Donors

Between 2007 and 2013, DAMH from multilateral donors has steadily increased. This funding has been directed through the European Commission, WHO, WBG and other UN agencies such as UNICEF. However, the funding is often earmarked, rather than flexible, and is therefore directed to projects tackling a specific issue rather than systemic improvements of the mental health services of a particular country. For example, the WHO reports that much of the funding it receives for mental health is specified by disease, condition or issue. While WHO uses its very limited flexible funding (derived from assessed contributions from member states) to support improvements in line with the MHAP 2013-2020 (i.e. improvements in national legislation, policy development and service delivery), the larger proportion of funding for its work is earmarked for specific issues. Moreover, a large proportion of donor money is for research (including research into implementation models or initiatives) rather than service delivery and larger scale mental health reform.
Systemic change has been possible through WHO programmes using the momentum generated by a response to a catastrophic event to ‘build back better’. The WHO produced a publication detailing this work in 2013 including improvements in the mental health system of Sri Lanka post-Tsunami in 2005 (with funding from Finland and other donors and sustained through domestic funding). More recent examples include: the improvement of the mental health system in the Philippines post-Typhoon Haiyan in 2013 (with funding from DFID); and improvements in the mental health system in both Sierra Leone and Liberia post-Ebola in 2014 (with funding from a range of donors including the Carter Centre). Such improvements in the overall legal and policy framework as well as a national and local capacity, have helped provide long term, sustainable changes in a country’s mental health service provision.

Other organisations that have been able to focus on systemic change and increase the universality of mental health service provision include the EU Commission, UNICEF and GFATM. The EU Commission has worked with national authorities through a group of governmental experts on mental health to put the “European pact for mental health and well-being” into effect since 2008. A yearly brochure (the EU Compass for Action) was released monitoring policies and highlighting mental health projects and progress across Europe. They have also funded projects that include: a joint action for dementia, a pathway for health minds in the workplace, implementing suicide prevention programmes and the creation of mental health brochures, the Mental Health Promotion Handbooks.

UNICEF integrates mental health into existing projects, and is working to create a methodological framework to develop the tools to improve data collection and evidence in the mental health of adolescents. Meanwhile organisations such as the GFATM often provide funding for mental health specifically linked to relevant services such as counselling for people living with HIV/AIDS.

4.2.3 Philanthropy

Overall, health is the main sector receiving funding from philanthropic donors (53% from 2013-2015); with the Bill and Melinda Gates Foundation (BMGF) being the largest donor at 72% of total philanthropic giving for health and reproductive health. The largest provider of DAMH (30% from 2000-2015) remains private philanthropy. Funding from trusts and foundations is frequently channelled through NGOs and foundations to deliver projects at country level. Some of these projects are focused on long-term mental health systemic change, but many are focused on specific populations or issues of priority to the donor. US-based foundations dominate the philanthropic mental health donor landscape. BMGF has funded broader psychosocial work and humanitarian response programmes, and specifically maternal mental health projects. The MacArthur Foundation has a history of funding US-focused work on incarceration and mental health, youth and mental health, law and mental health, and reproductive health and mental health. The Carter Center Mental Health Program focuses on mental health in Liberia, however their geographical reach has grown with their journalism fellowships to include work in Qatar, the UAE and Colombia.
Outside the US, the Wellcome Trust is a highly influential funder of mental health research. There has also been extensive federal research funding on global mental health by Canada, US, UK, EU, South Africa, India, Mexico, etc. Many of these, particularly US federal research funding, are the sources of funding for demonstration projects that are currently underway and through which researchers are collaborating with governments on mental health scale-up research. Fondation d’Harcourt focuses on capacity building and systems strengthening, maternal mental health, and psychosocial support to implement projects on the ground. The Qatar Foundation funds the annual World Innovation Summit on Health (WISH): this year it will feature a discussion and new report on depression and anxiety. The Tata Trusts in India work on advocacy and on the training of mental health professionals. The Open Society Foundation supports mental health work, in particular around human rights in eastern Europe.

**Box 1: Breakdown of NCD Spending 2000-16**

Compared to the other health focus areas, NCDs received relatively little attention until recently. Funding has increased for NCDs 9.5% annually, on average, since 2000, though it dropped slightly in 2016 to US$643.8 million. 2016 funding for NCDs was just 1.7% of total DAH, the main channels of assistance NGOs and WHO.

Within the NCDs, support for mental health programmes increased by 4.9% annually from 2000 to 2016, and mental health received US$130 million in 2016 (20% of NCD DAH). Antitobacco programs received $103 million (16%) of NCDs DAH whilst other programme areas were supported with $411 million in 2016.

Private philanthropy provided the bulk of funds in this area (US$245 million), channelled through NGOs and foundations and, to a lesser extent, UN agencies. UN agencies, led by WHO and PAHO, channelled $173 million, with contributions from the US ($23 million), the UK ($25 million), the Gates Foundation ($21 million), and others.

4.2.4 Conclusion

In the short term at least getting more funding into global mental health will be most quickly achieved through existing entities, combined with leveraging a range of ‘entry points’ across the health and development sectors. This will require strong, consistent ‘one-voice’ advocacy to maintain existing spend, and encourage the re-prioritisation of spending towards mental health.

4.3 Quantum and Type of Funding Needed for Mental Health

Before developing a set of financing mechanisms to support different aspects of the scale up in mental health services in LMICs, we must establish a macro view of the size of the ‘ask’ i.e. an estimate of...
what needs to be funded in total before then establishing who or how this would be paid for. Stakeholders know that we will not be able to fund everything, everywhere, and careful prioritisation of scarce resources will have to be made geographically, and in terms of coverage and service delivery. These decisions will be challenging but we have to start somewhere.

The following section attempts to set a macro ‘baseline’ for the funding required in terms of quantum and profile of spend. It is necessarily illustrative, in some parts speculative, and in all aspects intended as a start point to initiate discussion and collective decision making between the global mental health community, host countries and donors.

### 4.3.1 Principles behind the Funding Baseline

Whilst the idea of scaling up mental health services in LMICs has been discussed for years, the obvious comment regarding recent momentum to fund global mental health in LMICs is that significant levels of funding will be required to achieve catalytic impact on the scale being proposed. The principle behind fund usage should be to generate maximum direct impact in LMICs, primarily measured by improving overall mental health systems to enable the delivery of effective and sustainable services, and reduce the disease burden. Countries are increasingly determined to ensure the implementation and delivery of health for all through UHC; the provision of mental health services is a critical component of this target.

Therefore, the funding baseline will need to be ambitious enough to achieve catalytic change and wide coverage, yet also realistic in the context of a challenging fundraising environment rich in competing demands from other health (and non-health) sector initiatives and programmes. It will also need to be ‘sellable’ to the donor community and easily translated into actionable programmes.

**In terms of scaling up mental health service delivery in LMICs, we will not be able to do everything, everywhere, and careful prioritisation across geographies, populations and programmes will be required. However we first need to set an illustrative, realistic macro baseline of what to fund, and where, before we can design a suitable instrument to fund it.**

### 4.3.2 Baseline Assumptions:

- Additional external funding should go where the need is greatest and funding lowest (LMICs), acknowledging that countries must have the will and capacity to develop, and be open to change (refer to Phase 1 findings).
- In the short term additional mental health funding is likely to be most easily derived from existing development commitments; where possible mental health will be integrated with other ‘entry points’ or programmes.
- External ‘new’ funding will not exist in perpetuity, but focus on building strong and domestically sustainable global mental health ecosystems across LMICs within 10-15 years.
- Costing estimates are not promoting freestanding/vertical programmes, rather the integration of scaled up mental health care into existing care systems (e.g., primary care clinics, NGOs, schools) to maximize the efficiency of resource investments.
- Financing and implementation plans will be country-led, and respond to country-level priorities. Funding and action packages will need to be customised and adapted to each country’s culture, context, and only after careful local consultation.
- Donor preferences/restrictions will need to be taken into account, as will that of LMIC governments, and may impact on the specifics of how funding is deployed in different countries.
- Evaluation/monitoring will be a part of each action to improve data collection, efficiency of service delivery and implementation research over time.
4.3.3 The Funding Gap

The current average spend on mental health in LICs is US$0.02 pppa\textsuperscript{77}. Overall, research suggests that the minimum spend on mental health in LICs should be somewhere between US$1 and US$3 pppa\textsuperscript{78} and the recommended amount of spending required domestically for LMICs as a whole is assessed as US$3 to US$4 pppa\textsuperscript{79}. Given the vast numbers of people involved, a target spend of US$4 pppa is deemed to be beyond the ambition of this instrument, although there is no reason that it could not be reset as an upper-end target at a later date should resources become available domestically. It should also be noted that US$1 pppa is well below expert recommendations on minimum adequate spend, and is only to be considered as an interim target\textsuperscript{80}.

Therefore for the purposes of the baseline it will be assumed that the lowest target spend on mental health in LMICs will be US$1 pppa (5x current spending), with a realistic upper-end target of US$3 pppa (15x current spending) across all LMICs. A graduated approach to funding will be taken as programmes mature and local circumstances and absorption capacity adjusts, starting at US$1 pppa in the early years, and increasing up to US$3 pppa by 2029.

The thirty-one LICs have a collective population of 688 million, and the fifty-three lower-middle income countries a collective population of 3.05 billion\textsuperscript{81}, a combined total of 3.74 billion people. To fund increased mental health services to the populations in all eighty-four LMICs to a value of US$1 pppa would require US$2.99 billion p.a. above current average spend (or US$3.74 billion p.a. in total). To fund increased mental health services to the populations of the same countries at US$2 pppa would require US$6.7 billion p.a. and at US$3 pppa US$10.5 billion p.a. above current spend (or US$7.41 billion p.a. and US$11.22 billion p.a. in total respectively). Assuming a target spend of US$1 pppa (minimum) and US$3 pppa (maximum), the mental health funding gap across all LMICs is between US$3 billion and US$10.5 billion per annum, or US$30 billion and US$105 billion over 10 years.

See overleaf.
Table 2: Mental health treatment packages for each spending level

<table>
<thead>
<tr>
<th>LMIC Mental Health Spending</th>
<th>% of Total Health Expenditure (THE)</th>
<th>Treatment Packages and Population Coverage</th>
</tr>
</thead>
</table>
| **$0.20 pppa** (current level) | 0.5% THE | ▪ Completely inadequate  
▪ Average treatment coverage for:  
  o ~10% of the population  
  o 3.7% of major depressive disorder, 2.3% of anxiety disorder, 1.0% of cases of substance use disorder  
▪ Very basic primary care services to those with urgent unmet need |
| **$1 pppa** (core package) | 3% THE | ▪ Basic care package (“well below expert recommendations”, “not adequate” and a “short term goal”)  
▪ Average treatment coverage for:  
  o 22% of the population  
  o 33% of cases with depression, bipolar disorder, alcohol misuse  
  o 65% of cases with psychosis and epilepsy  
▪ Basic primary care services to those with urgent unmet need, e.g.  
  o Brief physician advice for alcohol use disorders  
  o Episodic treatment for depression with older anti-depressant drugs (e.g. tricyclic antidepressants) |
| **$2 pppa** (expanded package) | 6% THE | ▪ Minimum recommended level (MHAP target coverage levels)  
▪ Average treatment coverage for:  
  o 49% of the population  
  o 50% of cases with depression, bipolar disorder, alcohol misuse  
  o 80% of cases with psychosis and epilepsy  
  o 50% of cases of anxiety disorder  
  o 33% of cases of childhood behavioural disorders  
▪ Expanded primary care services e.g.  
  o Brief physician advice for alcohol use disorders  
  o Episodic psychosocial treatment for depression with anti-depressant and anti-epileptic drugs |
| **$3 pppa** (comprehensive package) | 9% THE | ▪ Comprehensive care package  
▪ Average treatment coverage for:  
  o 75% of the population  
  o 75% of cases with depression, bipolar disorder, alcohol misuse  
  o >80% of cases with psychosis and epilepsy and anxiety disorder  
▪ Community based treatment  
▪ Expanded primary care services e.g.  
  o Brief physician advice for alcohol use disorders  
  o Episodic and maintenance treatment for depression with anti-depressant and anti-epileptic drugs |

Source: ODI Insight Report Investing in Mental Health in LICs December 2016
4.3.4 The Funding Model

Evidence indicates that a graduated approach to securing additional funding for mental health is more likely to be successful, with programmes and spending targets increasing as local circumstances change and absorption capacity adjusts. It will be different in each country depending on a range of contextual factors, and careful consultation will be required to tailor the funding model to specific environments, geographies and circumstances.

It is assumed that any additional funding mobilised will not exist in perpetuity, but focus on building a strong global mental health ecosystem across LMICs by 2030 in line with the SDGs, and the approach outlined in the MHAP 2013-20. That will require funding across the 11 years from 2019 to 2030, with a graduated approach as programmes mature. Table 3 shows an illustrative model for how funding could be profiled across an 11-year period:

**Table 3: Illustrative Mental Health 10-year Funding Profile across LMICs**

<table>
<thead>
<tr>
<th>Year</th>
<th>Mental health spending targets across LMICs (pppa)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yr 0 (2019)</td>
<td>$0.2</td>
</tr>
<tr>
<td>Yr 1 (2020)</td>
<td>$0.8</td>
</tr>
<tr>
<td>Yr 2 (2021)</td>
<td>$1.0</td>
</tr>
<tr>
<td>Yr 3 (2022)</td>
<td>$1.2</td>
</tr>
<tr>
<td>Yr 4 (2023)</td>
<td>$1.5</td>
</tr>
<tr>
<td>Yr 5 (2024)</td>
<td>$1.8</td>
</tr>
<tr>
<td>Yr 6 (2025)</td>
<td>$2.0</td>
</tr>
<tr>
<td>Yr 7 (2026)</td>
<td>$2.2</td>
</tr>
<tr>
<td>Yr 8 (2027)</td>
<td>$2.5</td>
</tr>
<tr>
<td>Yr 9 (2028)</td>
<td>$2.8</td>
</tr>
<tr>
<td>Yr 10 (2029)</td>
<td>$3.0</td>
</tr>
</tbody>
</table>

The Year 0 figure of US$0.2 pppa is to fund, across LMICs, an assessment of domestic needs and capacity, a stocktake of what is underway and working already, an evaluation of other health and non-health sector programmes that may provide 'entry points', and to begin data collection and evaluation. The Year 1-3 figure of ~US$1 pppa represents the minimum starting point to begin a basic package of care with reasonable coverage levels for selected priority conditions and countries. The increase of spending targets to US$2 pppa (Yr6) and US$3 pppa (Yr 10) will deliver a more comprehensive provision of services and improved country and population coverage, recognising that domestic health systems will need to increase capacity gradually.

Based on this illustrative model, a LMIC with population of 10 million people would require total funding of US$190 million over 10 years to build a sustainable mental health ecosystem. A LMIC with 50 million people would require total funding of US$950 million over 10 years and a LMIC of 100 million people would require total funding of US$1.9 billion over 10 years (or an average of US$190 million p.a). This is illustrated in Table 4 below.

The illustrative spending target profile for 2019-2030 outlines a graduated approach to spending increasing from US$1 pppa (Yr 2), to US$2 pppa (Yr 6) and finally US$3 pppa (Yr 10) as domestic health system capacity increases. This profile will be customised according to contextual factors after a Yr0 assessment of need which is already underway, and an evaluation of appropriate 'entry points'. Data collection and evaluation will be continuous throughout. It should be noted that the scale up of services at country level is not necessarily linear so decisions on packages and services will require thorough evaluation of needs, resources and country priorities.
As a comparison total DAH amounted to US$37.6 billion in 2016 of which DAMH was ~0.4% or US$150 million. Table 4 also shows that assuming DAH remains at 2016 levels, and no ‘new’ or additional mental health funding, DAMH covering 1 billion people in LMICs at a peak spend of $3 pppa in 2030, would account for 8% of total DAH. Total DAH of $37.6 billion in 2016 was spent in the following way:

- 29.4% to maternal, newborn, and child health (US$11 billion);
- 25.4% to HIV/AIDS (US$9.5 billion);
- 9.6% to health system strengthening and sector-wide approaches (US$3.6 billion);
- 6.6% to malaria (US$2.5 billion);
- 4.0% to tuberculosis ($1.5 billion);
- 3.9% to other infectious diseases (US$1.46 billion);
- 1.7% to non-communicable diseases (NCDs) including mental health (US$0.6 billion).

### 4.3.5 Universality v Prioritisation

Accepting we will not be able to do everything, everywhere, careful prioritisation across geographies, populations and programmes will be required, and challenging decisions made about where funding is prioritised. For example, would it be preferable to achieve some increase (e.g. $1 pppa or x5 current spend) in mental health spending across all 3.7 billion people in LMICs (universality), than achieve a larger increase ($3 pppa or x15 current spend) across a billion people, but which only represents only ~30% of the LMIC population (prioritisation). It is beyond the remit of this paper to make recommendations around what is clearly a political decision. However, from a practical perspective LMIC populations are growing rapidly (i.e. universality will become increasingly challenging) and some of the most populous LMICs also tend to be those with the most rapidly increasing GDPs, and may therefore be in a better position to mobilise domestic resources later.

### 4.3.6 Dealing with the most populous LMICs

---

**Table 4: Illustrative 10-year spending profiles in LMICs (US$ millions)**

<table>
<thead>
<tr>
<th></th>
<th>Yr 0 (2019)</th>
<th>Yr 1 (2020)</th>
<th>Yr 2 (2021)</th>
<th>Yr 3 (2022)</th>
<th>Yr 4 (2023)</th>
<th>Yr 5 (2024)</th>
<th>Yr 6 (2025)</th>
<th>Yr 7 (2026)</th>
<th>Yr 8 (2027)</th>
<th>Yr 9 (2028)</th>
<th>Yr 10 (2029)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIC MH spending</td>
<td>$2 m</td>
<td>$8 m</td>
<td>$10 m</td>
<td>$12 m</td>
<td>$15 m</td>
<td>$18 m</td>
<td>$20 m</td>
<td>$22 m</td>
<td>$25 m</td>
<td>$28 m</td>
<td>$30 m</td>
<td>$190 m</td>
</tr>
<tr>
<td>profile for 10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>million people</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(US$0 millions)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LIC MH spending</td>
<td>$10 m</td>
<td>$40 m</td>
<td>$50 m</td>
<td>$60 m</td>
<td>$75 m</td>
<td>$90 m</td>
<td>$100 m</td>
<td>$110 m</td>
<td>$125 m</td>
<td>$140 m</td>
<td>$150 m</td>
<td>$950 m</td>
</tr>
<tr>
<td>profile for 50</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>million people</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(US$0 millions)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LIC MH spending</td>
<td>$20 m</td>
<td>$80 m</td>
<td>$100 m</td>
<td>$120 m</td>
<td>$150 m</td>
<td>$180 m</td>
<td>$200 m</td>
<td>$220 m</td>
<td>$250 m</td>
<td>$280 m</td>
<td>$300 m</td>
<td>$1.9bn</td>
</tr>
<tr>
<td>profile for 100</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>million people</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(US$0 millions)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LIC MH spending</td>
<td>$0.2 bn</td>
<td>$0.8 bn</td>
<td>$1.0 bn</td>
<td>$1.2 bn</td>
<td>$1.5 bn</td>
<td>$1.8 bn</td>
<td>$2.0 bn</td>
<td>$2.2 bn</td>
<td>$2.5 bn</td>
<td>$2.8 bn</td>
<td>$3.0 bn</td>
<td>$19 bn</td>
</tr>
<tr>
<td>profile for 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>billion people</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(US$0 billions)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH spending</td>
<td>0.5%</td>
<td>2.1%</td>
<td>2.6%</td>
<td>3.2%</td>
<td>4.0%</td>
<td>4.8%</td>
<td>5.3%</td>
<td>5.8%</td>
<td>6.6%</td>
<td>7.4%</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>profile for 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>billion people</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>as a % of 2016</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DAH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

FINANCING GLOBAL MENTAL HEALTH
The five most populous LMICs (Bangladesh, India, Indonesia, Pakistan and Nigeria) have a combined population of 2.182 billion, or 58% of the total population (3.74 billion) across all eighty-four LMICs. The remaining seventy-eight LMICs have a combined population of 1.56 billion, or 42% of the total. Given the diversity and breadth of actors playing a role in addressing mental health, not least that it is often bundled with the provision of other health or social services, we do not expect that one body will solely deliver a catalytic impact on global mental health across all LMICs, including the five most populous, as the numbers are just too significant. Decisions will have to be made as to where funding gets prioritised both geographically, and recognising that additional funding mobilised for mental health will also likely be channelled through a range of implementing organisations across LMICs. Therefore, we suggest the following options:

1. **Prioritise achieving the broadest population coverage over having a catalytic impact.** In practice this risks stretching resources too thinly, and funding would be unlikely to ever rise above US$1 pppa. Potential ethical issues exist where demand for mental health services is created, which then can't be met, and programmes insufficiently funded to make an impact.

2. **Prioritise catalytic impact over population coverage.** In practice this would mean that just a small percentage (10-20%) of the eighty-four LMICs would be funded for catalytic mental health service scale up, but the programmes would be very strong. Deciding which countries and populations to direct funding towards would be extremely challenging. Countries able to mobilise their own resources would broaden coverage.

3. **Prioritise coverage and catalytic impact, but reduce total population coverage to a more realistic level.** This could be achieved, for example, by:
   a. In the most populous countries scale-up mental health services in just one or two provinces or states to demonstrate what is achievable, but without trying to provide whole country coverage (e.g. deliver a mental health programme in the poorest state in India, Chhattisgarh, population 25.5 million, where 40% of people live below the poverty line). This could reduce population coverage by ~2 billion.
   b. Do not operate in countries in Phase 1 as either "Not yet open for change." This has the potential to reduce the number of targeted countries from 83 to 41 and reduce population coverage by ~550 million.

This paper recommends that the most populous LMICs should be included, but only on the basis of providing coverage across one or two states or provinces to avoid resources being overly focused in just a few countries or regions i.e. the third option above.

### 4.3.7 Sustainability of MH Spending post-2030

It will be important from the outset to clarify the sustainability of programme support, including beyond 2030 which was set in Phase 1 as the initial target for building strong mental health ecosystems across LMICs. A key assumption of the financing mechanism is that by 2030, the majority of mental health spending in LMICs should be self-funded through domestic resource mobilisation, recognising that LMICs have limited resources at their disposal and are already making difficult trade-off decisions between competing funding priorities.

The first is to convince LMIC governments of the health and social benefits an increase in mental health spending will bring, but more importantly with respect to scaling up service delivery, the economic benefit. Using data from an analysis of global return on investment\(^\text{86}\) show that 5,000 Healthy Life Years (HLYs) per 1 million population could be gained if LMIC mental health spending was $1 pppa and 13,000 HLYs for $2 pppa. $3 pppa could be expected to be 50% again over the $2 package, so circa 20,000 HLYs per million of population for $3 pppa. Scaling up mental health
treatment would also reduce public healthcare spending, increase workforce productivity and longevity, improve opportunities for individuals and families, and generate an economic dividend associated with increased HLYs, estimated to be a return of between $2-4 in better health and ability to work for every $1 invested in mental health treatment\textsuperscript{87}.

Therefore, a LMIC with a population of 50 million could see net economic benefit of ~$95 million p.a. based on a return of $2 for every dollars spent on mental health services, itself a conservative estimate. It is on this basis that LMICs should be encouraged to prioritise domestic mental health spending and for adding a mental health component to existing development programmes. It also forms the basis for the sustainability of LMIC mental health programmes when international funding ceases. Whatever scaled-up financing and implementation plans are put in place, they will need to be integrated, country-led, and respond to country-level priorities. But domestic governments must be incentivised to re-invest in mental health from the start to capitalise on the health, economic and social benefits. It is recommended that the economic benefit of scaling up mental health services is used to shape LMIC governments to add a mental health component to existing programmes and increase domestic resource allocations for mental health. An example of a LMIC re-investment programme to establish a sustainable mental health ecosystem is shown at Figure 5.

\textbf{Figure 5: Illustrative Sustainability Model for LMIC Mental Health Ecosystem}

\includegraphics[width=\textwidth]{figure5.png}

\subsection*{4.4 Conclusions}

An illustrative baseline of what to fund, and where, must be set before we can design a suitable instrument(s) to fund it. We will not be able to do everything, everywhere, and careful prioritisation of resources across geographies, populations and programmes will be required. The fundraising target will need to be ambitious, realistic, achievable and sellable. Assuming a target spend of US$1 pppa (minimum) and US$3 pppa (maximum), and a total LMIC population of 3.74 billion, the mental health funding gap across all LMICs is between US$3 billion and US$10.5 billion per annum, or US$30 billion and US$105 billion over 10 years. This is unachievable and decisions will have to be made on what to realistically fund, and where.

A realistic upper-end target spend to achieve catalytic mental health service delivery across LMICs is US$3 pppa, or 15\times times the existing spend. A graduated approach to achieving this target should be taken, starting at US$1 pppa in the early years, and increasing up to US$3 pppa as programmes mature and local circumstances and capacities adjust. An illustrative spending profile for 2019-2030
indicates a graduated approach to spending from US$1 pppa (Yr 2), to US$2 pppa (Yr 6) and finally US$3 pppa (Yr 10) as domestic health system capacity increases\textsuperscript{88}. This indicative profile will be customised according to specific contextual factors after a Yr0 assessment of need already underway and any appropriate ‘entry points’. Data collection and evaluation will be continuous throughout.

An essential element of up scaling mental health service delivery will be to incentivise domestic resource mobilisation to generate and capitalise on the economic, social and health benefits of the programme and deliver programme sustainability. The economic dividend for up scaling mental health spending will take some time to flow through, but it is estimated that within 10-15 years of the programme starting, re-invested economic dividends could generate a self-sustainable mental health model for the long term. This should be initiated from the start with gradual, conditional increases in domestic resource mobilisation required as programmes expand.

5 Options to Increase GMH Financing

5.1 How to think about financing Global Mental Health

Now that we have determined a fundraising target, the purpose of this section is to outline a set of financing mechanisms that can enable a range of stakeholders to participate in making an incremental contribution towards meeting this target. It should be noted that the implementing actors that would receive these additional funds may range from country governments, implementing development organisations, charities, NGOs, and private programmes.

5.1.1 Introduction

Existing financial resources dedicated to global mental health fall far short of need, especially in low resource settings where significant international resources will be required to scale up support. Current funding sources for mental health, are insufficient in scale, disbursed irregularly, and provide uncertain financial flow which may undermine efforts to build sustainable mental health ecosystems in LMICs. This warrants a new approach which should examine both existing and new sources of financing and ways to leverage them for catalytic impact.

In response to calls for scaling up mental health service delivery in LMICs, and after observing the broader trends in health sector financing, a number of proposals for ‘innovative’ financing mechanisms have been advanced by the mental health community including by the World Bank Group\textsuperscript{89} and by Harvard University. These include ‘sin taxes’ on products harmful to health (e.g. tobacco, alcohol), social impact financing (e.g. green bonds), and building on other capital market financing initiatives such as the GAVI Alliance’s International Finance Facility for Immunization (IFFIm), which front-loads investments by using long-term pledges from donor governments to sell ‘vaccine bonds’ in capital markets, or the Global Fund to Fight AIDS, Tuberculosis and Malaria’s (GFATM, or Global Fund) Debt2Health initiative, which redirects funds for debt repayment by recipient countries to domestic health investments. Other options, suggested during the consultation for this paper, include to initiate “mental health impact assessments” for development packages (in the same vein as environmental impact assessments); debt-for-mental health swaps through which donor countries swap payments by debt-distressed countries for local health investments\textsuperscript{90}; and examination the Disability Empowerment Concerns Trust, where six disability charities derive income from pooled investments in South Africa\textsuperscript{91}.

5.1.2 Traditional v ‘Innovative’ Finance

Before pursuing this route further, an overarching and important point that applies not only to proposals for an ‘innovative’ finance strategy for global mental health, but to similar approaches taken across the global health and development sector, is that there is often a temptation to create an
innovative financing structure for the sake of it, largely as an excuse for (or in the absence of) achieving traction through the traditional fundraising apparatus. However, this underplays the full potential of innovative financing, which is to create a more effective financing system and more efficient operations for the programmatic entity, not just simply unlock additional capital. For example, IFFIm was created because Gavi needed to frontload pledges to support vaccine catch-up campaigns; now that Gavi has moved to a more predictable steady-state, IFFIm enables Gavi to commit to long term procurement and vaccination programmes.

Therefore, finance mechanisms that propose to support the expansion of mental health service delivery must be designed with the specific financing challenge the mechanism is seeking to solve in mind – namely what is the shape or profile of the designated spend and how does the financing mechanism match that. A successful financing mechanism should be “more than money” as ultimately requests for funding from multiple different organisations and sectors are (largely) directed to the same pool of donors i.e. there is competition across the social sectors for the same capital. If the most appropriate funding for the specific organisation’s activities is traditional grant financing, then the question of financing mechanism match that. A successful financing mechanism should be “more than money” as ultimately requests for funding from multiple different organisations and sectors are (largely) directed to the same pool of donors i.e. there is competition across the social sectors for the same capital. If the most appropriate funding for the specific organisation’s activities is traditional grant financing, then the ‘ask’ should be framed as such. In contrast, if a specific financing mechanism, innovative or not, is proposed, it will be most impactful if it is framed as delivering additional value compared to a traditional grant (not forgetting that innovative financing mechanisms can appeal to donors in their own right). The financing mechanisms outlined here are designed with this principle in mind; that the benefitting organisation(s) would still choose to use the proposed structure even if there were no limitations on traditional replenishment funds.

5.1.3 Sources of Finance/Funding Mechanisms

Funding for mental health comes from a combination of national governments, international organisations, bilateral donors, trusts and foundations and individuals paying out of pocket. Among these, finding ways to expand the volume of funding from these different sources will be necessary. Recent reports have provided number of examples and ideas92 93. This paper seeks to highlight some particularly promising examples.

- **National governments.** The funds used to deliver mental health service provision at country level vary greatly. Within domestic governments several departments may be funding different aspects of mental health (e.g. health and social service provision through Ministries of Health or Welfare, and support for children with intellectual disabilities through the Ministry of Education) and an increase in funding for mental health could impact the budgets of a number of ministries providing mental health services. In LMICs a substantial amount of mental health treatment is met by out-of-pocket payments94 as most governments lack the funds to provide comprehensive mental health care. An overall increase in health budgets is frequently cited as essential to expand mental health services, yet countries could choose other approaches such as medical insurance programmes or social safety nets to include a more comprehensive approach to mental health services and treatment, funded by government expenditure. This would be the ideal approach under the objective of achieving UHC.

- **International organisations.** DAMH from international or multilateral sources has increased from 2005 to 201595. WHO is the largest source for funding for mental health among the international agencies, with the WBG, Global Fund for AIDS, TB and Malaria (GAFATM) and others such as UNICEF also providing funding. WHO could increase its budget space for mental health, but only if requested to do so by member states alongside voluntary contributions earmarked for mental health (or NCDs more broadly)96. The WBG has already produced a comprehensive assessment of how financing for mental health could be increased through its different financing mechanisms, and other options for scaling up financing97 98.
One specific channel for WBG funding could be expanding the GFF to include mental health given the target populations match those requiring development of mental health services; governments could easily include a mental health component into their submissions to the GFF e.g. for maternal mental health. The GFATM already provides some mental health support through HIV/AIDS counselling, but could choose to increase its counselling allocation, or other relevant services such as intravenous drug addiction treatment, if stakeholders decided mental health was a sufficient priority.

- **Bilateral funding.** Bilateral funding for mental health in LMICs has fluctuated in volume and focus from 2005-15 but could be increased either as part of overall donor efforts to improve UHC or through specific health or other sectoral issues that are of specific interest to donors. These might include maternal, newborn and child health (MNCH), promotion of human rights, equity (and the Leave No One Behind agenda), UHC, adolescent health and reproductive health. One of the greatest challenges of bilateral funding is that it tends to be provided in short-term increments: mental health potentially requires large up-front scale up costs and sustained funding (see Figure 5 below).

- **Trusts and Foundations.** Trusts and foundations are already a considerable source of mental health funding. An increase could be achieved either through an expansion of the programmes of existing funders or increasing the number of trusts and foundations that fund mental health. For example, as part of the global effort to raise and sustain large scale funding for polio, BMGF has helped unlock new funding sources by recruiting additional trusts and foundations and individual philanthropists. Global mental health could emulate that model by encouraging existing trusts and foundations to enlist the support of additional philanthropists to accelerate fundraising efforts. One potential group of philanthropists are ‘next generation’ philanthropists ('next-gen') who are in their 20s or 30s and are inspired to find causes that are not currently well funded, or where impact could be swift. This could be particularly well suited to a Mental Health Giving Pledge (see Section 6).

- **Individual giving.** In the first instance, remittances by diaspora populations are a source of funding of out of pocket health expenditure and this could be a source of increased financing in the future. Other means to generate external funds from individuals include public-facing fundraising campaigns to secure donations from individuals can help build overall awareness for an issue, and can influence bilateral funding allocations through match funding, or simply promoting greater understanding of popular support. A successful example is Rotary International’s longstanding support for the Global Polio Eradication Initiative where members have raised substantial amounts and influenced governments around the world, particularly in large donor countries, to invest in polio eradication. In some cases (e.g. Canada) donors have directly matched donations by the public. UNICEF receives funding from bilateral and multilateral donors and it also directly fundraises from corporates and individuals. If UNICEF launched a fundraising campaign for mental health, it could generate additional funding from all these sources. GFATM partners with RED to raise funds for its work on HIV/AIDS, TB and Malaria. Another organisation that could help generate additional funding from a range of sources is the International Federation for the Red Cross and Red Crescent (which already has a numerous mental health projects worldwide).

5.2 **Sourcing additional funding from other ‘Entry Points’**

Mental health is not just a health issue, but one that crosses sectoral boundaries and will require a collaborative, inter-sectoral approach to solve it. Key to success will be initiating strategic action across many different stakeholders, including governments, donors and civil society groups, working
collaboratively across sectors on the most impactful interventions. In the short term at least, the most viable approach to enabling increased funding for mental health is likely to be through broader cross-sectoral and broader development links, important to avoid the risk of a ‘competition’ for funding.

Mental health is part of the SDGs and linked to the successful delivery of several cross sectoral goals and boundaries. Mental health financing could therefore be increased by taking advantage of other ‘entry points’ into programmes that are already well funded and are preferred or higher priority areas of funding for donors or external funders. Investing in mental health could deliver benefits to other sectoral programmes and mental health components could be included in almost any existing national development programme. In the short term domestic governments in LMICs could consider adding a mental health component to existing programmes, or within whichever high priority development issue being funded in-country. The advantages of this approach are that the link between mental health and other sectoral issues is, in some cases, already well established, set-up costs would be minimal, it would use existing budgets that may not be fully allocated, and a mental health component could help other sectoral programmes reach their targets.

However it is not an entirely straightforward process and questions remain around how to practically 'tap' into other sectors. Challenges include: the need to develop technical tools and metrics specifically to engage with other sectors; mental health ineligibility for funding under existing rules; limited donor (and other stakeholder) appetite for including mental health explicitly where change is required; the need for mental health to be identified as an explicit, costed priority at an early stage; technical capacity would need to be developed for countries to make compelling applications; the unpredictability of funding profiles; funding and geographical foci might not fit mental health needs; is it still just taking money from one development area to another; and the perceived risk in trying new approaches to mental health. Certainly it will be necessary to build considerable political support at country, donor and global level to advocate for a fairer (larger) share of the funds for mental health, and which may not be forthcoming unless we can generate 'new' sources of funding. Among the largest sources of potential external funding for mental health are those outlined in Table 5. A more comprehensive version can be found in the Lancet DCP-3 paper.

---

Box 2: Non-communicable diseases (NCDs).

NCDs kill 41 million people each year, equivalent to 71% of all deaths globally, with over 85% of these “premature” deaths occurring in LMICs. The main types of NCD are cardiovascular diseases (like heart attacks and stroke), cancers, chronic respiratory diseases (such as chronic obstructive pulmonary disease and asthma), diabetes and mental health and neurological disorders. NCDs threaten progress towards the 2030 SDGs, which includes a target of reducing premature deaths from NCDs by one-third by 2030.

Given the already scarce and inadequate provision of mental health services and research, and the broader competing demands from the remainder of the health (and other) sectors for funding, questions remain about the relationship between mental health and the NCDs, and should they be separated from a fundraising perspective? The mental health definition already covers a wide spectrum, and incorporates ADHD to addiction, and thus donors may ignore what are very pressing needs in a society where for example cancer is seen as more important than depression.

Equally, there might be huge mileage in the NCD (and NTD) route, and there is work to do in the global mental health academic field to better elaborate and communicate the links and effective synergies, which could make the common financing easier to justify. NCDs and mental health are often co-morbid, providing extra incentive to treat them together. The proposed NCD Trust Fund might provide an opportunity to raise funds for mental health in collaboration with the wider NCD community. Ultimately the global mental health community needs to decide whether to pursue more unilateral and independent funding initiatives and financing mechanism(s), or whether to combine with – or only operate within - the broader alliance of NCDs.
### Table 5: Mental Health 'Entry Point Opportunities

<table>
<thead>
<tr>
<th>Entry Point Opportunity</th>
<th>Precisely What?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health system strengthening and UHC</td>
<td>Inclusion of mental health in decisions on workforce planning, health physical infrastructure and the commodities supply chain</td>
</tr>
<tr>
<td>Education</td>
<td>Improved services for children with learning disabilities, mental health conditions such as autism, mental health promotion for children in schools.</td>
</tr>
<tr>
<td>Humanitarian assistance</td>
<td>Mental health and psychosocial support for survivors of disasters and war, including refugees and other displaced populations, and building back more sustainable health systems after crises.</td>
</tr>
<tr>
<td>Adolescent thriving</td>
<td>Acknowledging the stage when many mental disorders initially present</td>
</tr>
<tr>
<td>Co-morbidities</td>
<td>Tuberculosis (TB), HIV/AIDS and depression, diabetes and depression[^106]</td>
</tr>
<tr>
<td>Promotion of human rights</td>
<td>Updating and implementing mental health legislation and policies in line with international human rights law</td>
</tr>
<tr>
<td>Reproductive Health</td>
<td>Counselling for those wishing to plan for a family; providing mental health services for women of child bearing age, pregnant, or recent mothers</td>
</tr>
<tr>
<td>Gender</td>
<td>Counselling for survivors of sexual and gender-based violence, recognising that MH is a gendered disease, affecting women &amp; girls differently to men &amp; boys</td>
</tr>
<tr>
<td>Leave No One Behind</td>
<td>Creating employment opportunities for people with mental disorders; improving community participation for people with mental disorders</td>
</tr>
<tr>
<td>Non-Communicable Diseases (NCDs)</td>
<td>The establishment of a multi-donor fund to catalyse financing for the development of national NCDs and mental health responses and policy coherence at country level[^107].</td>
</tr>
<tr>
<td>Maternal and child health</td>
<td>Postnatal depression; providing parenting and child rearing education for young parents; mental and substance-use services for children and youth[^108]</td>
</tr>
<tr>
<td>Climate change</td>
<td>Mental health resilience and lost economic opportunities</td>
</tr>
<tr>
<td>Work place /wellness at work</td>
<td>Introduce or strengthen programmes that promote and protect mental well-being in the work place</td>
</tr>
<tr>
<td>Disability</td>
<td>Investment aimed at treating mental disabilities and supporting those with physical disabilities who may also experience mental ill health.</td>
</tr>
</tbody>
</table>

[^106]: [106]
[^107]: [107]
[^108]: [108]

### 5.3 Mobilising Domestic Resources

Levels of public expenditure on mental health in LMICs are very low and 80% of funds go to mental hospitals. Whatever scaled-up financing and implementation plans are put in place, they will need to be integrated, country-led, and respond to country-level priorities, recognising that LMICs have limited resources at their disposal and are already making difficult trade-off decisions between competing funding priorities. Notwithstanding this there are clear incentives for domestic governments to invest in mental health. Mental health disorders can have a negative impact on economic productivity, and scaling up treatment can generate meaningful health, social and economic benefits. It is recommended that the economic benefit of scaling up mental health services is used to...
shape LMIC governments to add a mental health component to existing programmes and increase domestic resource allocations for mental health.

Data from recent analysis of global return on investment\textsuperscript{109} show that 5,000 Healthy Life Years (HLYs) per 1 million population could be gained if LMIC mental health spending was $1 pppa and 13,000 HLYs for $2 pppa. $3 pppa could be expected to be 50% again over the $2 package, so circa 20,000 HLYs per million of population for $3 pppa. Scaling up mental health treatment would also reduce public healthcare spending, increase workforce productivity and longevity, improved opportunities for individuals and families, and generate an economic dividend associated with increased HLYs, estimated to be a return of between $2-4 in better health and ability to work for every $1 invested in mental health treatment\textsuperscript{110}. Therefore a LMIC with a population of 50 million could see net economic benefit of \textasciitilde$100 million p.a. based on a return of $2 for every dollar spent on mental health services, itself a conservative estimate. It is on this basis that LMICs should be encouraged to prioritise domestic mental health spending and for adding a mental health component to existing development programmes. It also forms the basis for the sustainability of LMIC mental health programmes when international funding ceases.

5.4 Funding Profile for Interventions

Section 4 set out the illustrative macro-level profile of what increased mental health funding could finance in LMICs to achieve catalytic effect. Using the priorities of the MHAP 2013-20 as a starting point, and the findings of the Phase 1 report\textsuperscript{111} with regards to scalable action packages, it is possible to profile likely spend over time.

In Figure 6 the mental health interventions identified by Phase 1 of this work have been classified according to the expected ‘profile’ of associated spend to scale up services in LMICs. This is an illustrative profile, independent of the size of the spend, in order to explore what the appropriate financing mechanism(s) to support mobilising such funding might be i.e. is the profile consistent or a one-off upfront cost, does it increase or decrease over time, does it continue indefinitely or have a definitive end point, short or long term etc. The profiles and interventions are for illustrative purposes only and are independent of the total quantum of funds needed for interventions across geographies.

Whilst the model in Figure 6 is illustrative, it highlights that whilst it is possible to profile spend at the macro level, the specific funding profile for each country is likely to be different, and dependent on a range of factors (e.g. start point, country classification, current domestic spend on health and mental health, mental health programmes already operating, relevant ‘entry points’ and absorption capacity etc.), and with different actors and implementing agencies (and therefore, funders) participating at different parts of the mental health service delivery value chain. It also shows that whatever the quantity of funding along the graduated approach, it is possible to break down the spend within it according to broad principles, for example delaying full implementation of de-institutionalisation until community and district level care-systems have been strengthened, and prioritising community-based mental health care models. In addition, some interventions have more predictable and constant spending profiles such as mental health advocacy (to build national leadership), increased public awareness (tackling stigma), mental health legislation and policy (to keep up to date and in line with best practice) and contingency funding for crises.
5.5 Matching Interventions with Action Packages

Taking an investment banking approach of matching the liability, or the expected associated spending profile of the intervention, with the asset, or the expected financing stream, we have therefore sought to suggest a range of financing mechanisms that are appropriate for the different spending profiles. Spending profiles will be particular for each country or group of countries depending on a range of factors, but we can see from Figure 5 that some interventions will be low but consistent spend over the period of the financing mechanism, and some will peak and trough dependent on a range of factors such as the existing health and mental health infrastructure, political will and the speed with which changes can be made.

There will also be different financing mechanisms that suit particular donors or implementation stakeholders, recognising that there will be a range of different implementing organisations which may have different requirements in terms of funding sources and profile. For example, there may be some funding sources more willing and able to contribute early stage ‘risk’ capital and others who would prefer a more predictable spend over time once early stage progress and success is in evidence. Sin taxes and fiscal space expansion can serve health system strengthening efforts, while social bonds can support well-defined socially appealing interventions (i.e. subsidising mothers with substance use disorders to take care of their children and meet certain health outcomes; subsidising families to take care of elderly patients with dementia, etc)\(^1\)\(^2\).

Key to the overall success of the financing mechanism is to be able to play successfully across the funding source (including entry points) and implementation stakeholder spectrums to maximise efficiency, consistency and predictability of funding for when it is needed.
5.6 Conclusions

In the short term at least, the quickest, low-cost way to increase mental health funding in LMICs would appear to be by integrating mental health into existing development programmes. There are benefits to be gained towards achieving the SDGs by including a mental health component in other sectoral programmes, which could take advantage of large funded programmes and uncommitted budgets. There is also an immediate opportunity to work with the NCD community to raise funds through a proposed UN-WHO Multi-donor Trust Fund, although it is questionable whether the ‘entry point’ or NCD route would generate anywhere near the quantum of funding required to initiate a catalytic change in LMIC mental health service delivery.

Despite limited resources and competing funding priorities in LMICs, incentivising domestic resource mobilisation for mental health should be a key element of any scale up in mental health service delivery. LMICs should be encouraged to prioritise domestic mental health spending and for adding a mental health component to existing development programmes. There is a clear dividend to be gained that will not only contribute to higher economic productivity and opportunity, but also help advance progress towards the health and other SDGs. Importantly it will also underpin the sustainability of the mental health ecosystem beyond the duration of international development funding.

In the medium to long term, a new finance mechanism(s) that support the expansion of mental health service delivery will be needed to deliver catalytic change. These must be designed with the specific financing challenge the mechanism is seeking to solve in mind – namely what is the shape or profile of the designated spend, and how does the financing mechanism match it in the effective and efficient way. Although mental health is a multi-sectoral issue, decisions will be required around whether the mental health community should pursue ‘new’ funding outside the broader NCD community. If so, the fundraising strategy should be about “more than money” as ultimately requests for funding from multiple different organisations and sectors are (largely) directed to the same pool of donors i.e. there is risk of competition across the sectors for the same capital.
6 Options for Financing Mechanisms

At this early stage four main financing mechanisms have been identified that could address the different mental health intervention profiles and enable the participation of a wide range of funders into a range of mental health interventions. The purpose of these options is not to be prescriptive, or to suggest these are the only options, but rather to help shape the discussion and form a menu of options from which partners in mental health can consider how best to tackle the challenge. These emerging themes are not mutually exclusive, nor do the financing tools fall discreetly into categories across the spectrum of capital. Rather, these non-traditional financing tools and approaches can be used in different ways depending on the mental health issue and spending profile to be addressed. There will be considerable further work to be done to refine these options and to consider whether there will be other better suited to scaling up mental health delivery in LMICs once the parameters and aims of the financing mechanism have been agreed.

It is outside the scope of this paper to make recommendations about which organisation should manage and disburse the additional funds generated. This will be up to health policy makers, the mental health community and current and potential funders to determine. It could be an existing organisation (such as the WHO, UNDP or WBG), a collaboration of entities, or even a new organisation set up with a different governance structure. For simplicity this paper refers to MH.org as the financing mechanism(s). It would need a hosting agency and more information on potential options are included in the section below. This paper focuses on how to get more funds into mental health across the globe.

6.1 An IFF for Mental Health

6.1.1 General

An International Financing Facility (IFF) for Mental Health would address the need for critical investment into mental health infrastructure – both physical and training – whilst also addressing the challenge of interventions with a variable or ‘lumpy’ profile that donors and/or governments with regular budgets cannot typically fund. An IFF would allow donor governments to support large, variable spend by being able to utilise the capital markets to shift long term commitments for immediate use. Donors could also give contingent pledges to the facility that are activated in the event of an emergency to enable rapid deployment of funds. It could deliver the necessary increase in funding to meet the mechanism’s aims, and provided a stable, predictable source of mental health funding that enables donor countries to factor it into their health sector and budget planning. It would also allow a critical mass of finance to be used simultaneously for a range of implementation projects and an improvement in coordination between donors.

6.1.2 How it works

An IFF for Mental Health would not be a new disbursement mechanism or competing bureaucracy, but purely a facility that raises money. It would rely on donors’ commitment of streams of annual payments to the facility, and these long-term commitments would be the primary source of the IFF’s income. The IFF could then issue bonds on the basis of these commitments. The funds raised by donor commitments and by market borrowing could be quickly disbursed through existing mechanisms and instruments, in the form of grants rather than loans. The long-term stream of commitments would be legally binding, in order to provide security for investors to lend against. Depending on the structure of the facility, this could be either donor governments committing resources for use in LMICs, which would be grant funding, or LMICs leveraging the facility to frontload their own domestic spend on mental health. The rating and associated financing costs of the facility would depend on the creditworthiness of the funding commitments and the leverage of the facility.
6.1.3 Donor Benefit

Benefits include: a system of phased streams of annual payments in line with donor countries’ GDP could be established which would allow income to the Facility to build up over time to meet the mechanism’s targets; impact “2-for-1”, whereby long-dated pledges that only hit the balance sheet in the year they are disbursed could support large, near-term scale up; and if the facility were accessed by both donor funders for philanthropic disbursements, and LMIC governments for borrowing, indirect credit support to beneficiary countries who wish to frontload spending commitments to mental health.

6.1.4 Recipients Benefits (Implementing Governments and Agencies)

The existing IFFIm structure creates precedent for how this can be constructed and governed. However, like IFFIm, such an IFF would need to be, at least initially, captive to and associated with one implementing agency (the equivalent of a ‘Gavi for Mental Health’ and here referred to as “MH.org”). The advantage of such an IFF to an MH.org is again twofold, as while pledges to development agencies such as the Global Fund are not legally binding, pledges to an IFF can be. Implementing governments could utilise the facility to frontload their own spending commitments in mental health. Cost of financing and the rating of the facility will depend on the number of countries that sign up to the facility and the diversification that can be achieved (the larger and more evenly-spread the facility, the better). The inclusion of a middle-income country group would be powerful in terms of increased access to financing and solidarity.

By allowing donors to make long-dated, legally binding commitments, and providing a means to shift the timing of disbursements as programmes require, an IFF would meet an implementing agency’s need for funding certainty while providing advantages to donors through spreading payments. Even beyond scale up investment in infrastructure, resulting confidence to make long term programmatic commitments ahead of having cash in their accounts – even if donors either default or are delayed, the implementing agency can leverage the capital markets to release funds on the back of those pledges.

6.1.5 IFF Precedent: IFFIm

In response to the financing challenge for the MDGs identified at the Monterrey Development Conference in 2002, the UK Treasury developed the concept of an IFF (International Financing Facility), together with Goldman Sachs to allow the front-loading of development assistance during the period 2004-2015, with repayment occurring in the years 2015-2030 when it was assumed that the MDGs would have been met. The IFF was constructed to support the activities of the Global Alliance for Vaccines and Immunisation (now called simply the Gavi Alliance). In November 2006, the IFF for Immunisation (IFFIm) executed its inaugural US$1 billion financing and has since raised almost US$6 billion in the international capital markets. During the period 2006-2011 IFFIm allowed for a doubling of Gavi’s expenditure rate. This laid the foundation for Gavi’s scale as it moved from US$200 million per annum expenditure organisation to almost US$2 billion it is today.

IFFIm was designed as a mechanism that could convert long term, legally-binding donor pledges to cash upfront via the capital markets to enable the front loading of vaccine expenditure. Rather than increasing the quantum of capital, IFFIm shifts the timing of donor cashflows, which is particularly valuable for the introduction of a vaccine where there is a significant public health value of a cohort catch up campaign. IFFIm does not frontload the full pledged amount – it is currently capped at 58%, with the proportion of donor pledges not used to repay bond issuances released to Gavi in the year it is disbursed by donors and used to support routine immunisation.
It should be noted however that beyond the value of frontloading funding commitments where there is a specific spending need (such as a catch-up campaign), a critical value of IFFIm for Gavi is that it allows Gavi to sign programmatic commitments to countries totalling a value above its core balance sheet in the knowledge that even it does not have the cash on hand today, they have the means to access it via IFFIm and the long-dated donor pledges should traditional replenishment commitments not occur. The Sustainable Financing for Development Conference in Ethiopia in July 2015 highlighted the value of IFFIm and mechanisms like IFFIm in a broader application than currently employed:

6.1.6 Potential Mechanism Structures

*Figure 7: Where Donors Fund Recipients*

*Figure 8: Where Recipient Governments use the Facility to Frontload Funds at Low Cost*

6.2 Mental Health Capital Account

6.2.1 General

Recognising that funding health services, in particular mental health services, will require an element of long-term, consistent spending for some areas of programme implementation, an IFF or a ‘frontloading’ instrument is not suitable for this purpose. The financing mechanism could therefore also establish a “Capital Account” with its donors as part of an endowment approach. An endowment approach, or the creation of a capital account, is a way for development organisations to secure long-
term, predictable and sustainable funding while also putting a different ask in front of cash-strapped donors and thereby potentially opening ways for different donors to commit. This model has been employed effectively both in national settings (Australia’s Futures Fund), private endowments (universities) and in developmental settings (DFID and agriculture).

6.2.2 How it Works

Under this approach, donors (governments and philanthropists) invest in a Health Capital Account, or Investment Fund, and remain the owners of that asset. Investment returns from the fund (potentially over a certain hurdle if investors/donors required not just capital preservation but a return equal to their cost of capital, or a fixed amount each year) are paid out to the beneficiary – a developmental organisation. Because investment returns with appropriately-conservative risk strategies are typically not more than 5%, this approach is unlikely to deliver a huge contribution to LMICs mental health needs – i.e. it would require US$1 billion in donor capital to disburse US$50 million annually – but it would provide something relatively rare in terms of developmental financing, which is a long term, reliable capital flow. This is well suited for funding certain programmatic needs such as mental health advocacy, policy, legislation, evaluation and data collection which are likely to require consistent, predictable spend over the life of the mechanism and beyond.

However, akin to a university endowment, the donors would still “own” their investment, meaning that such an approach potentially opens additional sources of funding (donor balance sheet compared to donor disbursements) alongside the traditional donor asks, as well as non-traditional donors. This would be an investment fund using money paid-in by donors that would be invested to generate financial returns over the longer-term (potentially similarly to the investment strategy of Gavi) – but that ultimately would be owned by the donors and they would have the residual claim over those assets.

6.2.3 Donor Benefit

While structured as a long term or perpetual fund, the owners of the fund would remain the donors, meaning that if the Fund were unwound that money would flow back to the donors, rather than the mechanism itself. This means that capital contributions to the Capital Account would be listed as an asset by the donors and not contribute to their fiscal deficit.

We would note that this approach only makes sense if requests for traditional donor pledges are insufficient to fully meet replenishment needs. The endowment approach can provide ongoing capital to a developmental organisation but in a way that is easier for donors to ‘swallow’. Furthermore, this approach provides a type of funding that is well suited to the ongoing and indefinite financing need of mental health services, in contrast to finite, ‘lumpy’, specific health interventions or programmes. However, this approach is the only mechanism of those assessed here that has the potential to access additional donor capital on top of the traditional donor government commitments.

6.2.4 Recipient Benefits: Implementing Agency(s)

The Fund would generate financial returns on an ongoing-basis which could be used to supplement programs and activities in mental health services, also reducing the reliance on donor replenishments. The proceeds could be paid to either one implementing agency or a range of groups – adequate governance and disbursement conditions (see “Engagement Principles”) would need to be defined. This endowment approach could also provide an accounting backing for grants payable, meaning that the mechanism could make programmatic commitments in the confidence that in the unlikely event that donors default on other pledges, they will be able to liquidate and utilise the Capital Account.
6.2.5 Mental Health Capital Account Precedent

The Australian Government uses this approach to support underfunded social sector liabilities (largely pensions), as well as smaller endowments to support specific uses such as the Medical Research Futures Fund. This approach has also been employed previously by the UK with the World Bank.

6.2.6 Mechanism Structure

This approach would work well for any developmental organisation that is already hosted by the World Bank as a Trust Fund, meaning that it can leverage the World Bank’s investment management expertise and platform, and not require the creation of an independent fund and contract fund manager. If structured as a Financial Intermediary Fund (FIF) at the World Bank, this model could leverage the investment management expertise of the World Bank, for which they would take a small fee (typically cost recovery), but also receive capital from sovereign members of the World Bank, sovereign non-members and non-sovereign entities provided the FIF legal requirements and WB due diligence requirements are met.

Figure 9: Mental Health Capital Account Structure

1. Capital is invested into a new Mental Health Capital Account, potentially managed by the World Bank; investors own shares in that Fund.
2. Funds are invested in an investment portfolio through the WB Treasury Investment Management Department.
3. If appropriate, funds could be co-invested alongside the IFC into qualifying new loans in health.
4. If this were to happen, capital repayments from the loans will flow back to the liquidity portfolio.
5. The investment portfolio passes all investment returns to the Health Capital Account.
6. Annually the HCA will grant a dividend to the developmental organisation (MH.org) from the overall portfolio return.

6.3 Mental Health Guarantee Facility

6.3.1 General

Lending from multilateral development banks (MDBs) forms a significant part of LMIC financing. However, as it is borrowing that will have to be paid back, evidence suggests that these funds are
typically deployed into ‘productive’ sectors such as infrastructure. With an ever-larger number of organisations competing for donor government support, a way to increase financing without requiring additional paid-in capital or cash disbursements from donor governments could be contingent financial support. This may be used to insure lending portfolios of MDBs to allow LMIC countries to borrow beyond their borrower limit where the use of proceeds is for mental health.

6.3.2 How it Works

Guarantees span a range of specific applications, from loan repayment to first-loss investment coverage. A guarantor uses grant funding to cover a predetermined amount of an investment in the event that it is unsuccessful. The assurance that an investor will be repaid may make the investor more willing to enter into a transaction, in turn making funding available to programme implementers. The availability of cheap capital in the form of concessional loans could be a significant benefit to LMICs facing financing challenges for mental health. Whilst there are several sources of concessional financing, the funds are limited, and competition can be considerable.

A critical barrier that many LMICs governments face is a lack of access to working capital without which they are unable to expand mental health service delivery, hire and train new staff, make upgrades to facilities or equipment, or maintain an adequate stock of quality assured commodities. An MDB guarantee facility to expand the envelope or reduce the interest rate of concessional loans available to a LMIC. A donor guarantee would allow MDBs to make additional concessional loans to LMICs, conditional that the additional funds would be spent on mental health projects or system transformation. Recipient governments would participate if they deemed there to be future public health savings from early investment in developing mental health infrastructure. Because these are ultimately MDB loans, they would need to be repaid by recipient countries.

6.3.3 Donor Benefits

Guarantees are deemed to be contingent liabilities meaning that while they are irrevocable and legally binding, they are not counted as debt in the European accounting system. This means that donor capital committed for guarantees to MDBs would be additive to other Official Development Assistance (ODA) capital. These guarantees could also be structured to convert into cash disbursements in the event of a crisis or emergency needing up scaled mental health support.

Given the risk profile of the borrowers (LMICs), it is likely that guarantees would need to cover incremental MDB lending 1:1. This mechanism could be supplemented by paid-in capital but capital that is available to be disbursed would likely be more impactful elsewhere. This approach is already utilised by USAID and SIDA.

6.3.4 Recipient Benefits (Implementing Governments)

This approach would preserve national sovereignty and agency in managing mental health interventions and, by leveraging the existing MDBs infrastructure, would minimise setup costs. This would effectively increase the quantum of capital available to target LMICs at concessional rates, which is scarce and highly valued. A condition of accessing this could be demonstrated matched in-country spend, thereby ensuring an element of domestic resource mobilisation in LMICs when they have the capacity to do so.

6.3.5 Guarantee Precedent

In 2016 the UK implemented a Loan Guarantee Agreement with the WBG Covering an International Bank for Reconstruction and Development (IBRD) Loan to the Government of Iraq. The IBRD’s lending package amounted to three US$1 billion Development Policy Loans, conditional on Iraq committing to, and implementing, reforms in the areas of public expenditure, energy efficiency, and transparency of state-owned enterprises. This was limited by the IBRD’s internal rules on loan
exposure to any one country which constrains the extent to which it can increase its lending. A UK guarantee allowed the IBRD to increase the size of its loan by US$443 million covering a proportion of the loan principal, plus the equivalent a percentage of interest payments, for the expected 15 year life of the IBRD loan.

Another example is USAID’s Development Credit Authority (DCA) guarantee for global health which has unlocked US$4.8 billion in private capital for development since 1999. In global health alone, DCA has facilitated 29 health sector guarantees across 18 countries. USAID’s DCA guarantee supports these healthcare providers by enabling commercial banks to extend working capital loans to traditionally underserved sectors like health. The DCA guarantee de-risks lending by sharing the risk with the bank, reimbursing up to 50% of the value of a loan in the event a borrower defaults. Of note, DCA’s default rate across its entire portfolio is less than 3%. It should be noted that USAID is unique among bilateral donors in having a scaled, in-house, guarantee mechanism such as the DCA guarantee, and is the third largest guarantor in the world behind Overseas Private Investment Corporation (OPIC) and the International Finance Corporation (IFC).

### 6.3.6 Mechanism Structure

A new Mental Health Guarantee Facility would be established and capitalised at the World Bank. Its purpose would be to provide a 1st loss guarantee for concessional and conditional loans made by the IBRD to LMICs for mental health system transformation. The Guarantee Facility would be capitalised by donors (we estimate that the IBRD would seek to hold capital of approximately 33.3% against any lending) to back a broad portfolio of concessional loans to LMICs; most important at this stage would be expanding the envelope of concessional lending as opposed to driving down concessionality. The resources held in the Guarantee Facility would remain in the ownership of the donors, and would accrue an investment return, and released back donors once the loan balance was repaid. This would enable the World Bank to reassess the internal credit rating applied to LMIC risk, enabling country risk limits to be increased.

### 6.4 Giving Pledge

The other mechanisms developed to date have largely focused on traditional donors and implementing groups in global health and development. However, recognising that mental health is increasingly a focus for the new, younger generation of philanthropists, and that younger or smaller organisations or individuals globally are increasingly interesting in supporting this challenge, it is necessary to complement these other financing mechanisms with an option that allows for smaller scale, more widespread participation.

#### 6.4.1 General

To be effective, and to raise funds for mental health across the implementation spend profiles, it will be important to offer a route to new, private philanthropists, corporates and ‘smaller’ bilateral donors. Critical to this will be building the relationship between donor and recipient government as no donor want to be taken for granted, and the amount of money provided by a small donor can never be enough to make the recipient government pay much attention. No donor, however small, wants to be taken for granted or lose control, so the relationship must be about more than money. One way to attract this category of donor is by establishing a way for smaller donors and philanthropists to pool their resources but in a way that does not lose sight of their donation, and gives them a higher profile ‘seat at the table’ than if they had channelled their resources bilaterally.

#### 6.4.2 How it Works

A Giving Pledge would work by offering a significant opportunity for philanthropists, corporations, trusts, foundations and nongovernment partners to have a significant impact on the response to the
global mental health challenge. Closely linked to the advocacy campaign, partners would be invited to commit to give a percentage of their wealth or returns towards a mental health venture capital (VC) or ‘liquid’ fund that would allow the mental health community to engage with the widest range of stakeholders and funders, including ‘medium’ and ‘smaller’ ones (e.g. <US$10 million) who would not, for example, participate in a Capital Account. The point is funders and philanthropists can engage in a range of ways, for example:

- Corporates establishing a fund that gives Limited Partners, clients and/or employees an option to put returns over a hurdle into a mental health organisation/charity. For example in the UK Lloyds Banking Group staff voted for a £2m corporate partnership with Mental Health UK to be used to create new services.
- Smaller donor countries choosing to pool resources alongside a single major donor country as opposed to bilaterally.
- Grant-making trusts and philanthropic individuals can commit to giving a percentage of their returns or wealth towards mental health projects in particular countries

6.4.3 Donor Benefits

The main benefit from a donor perspective is that it allows the donor to have an interface with consumers/individuals/countries (which none of these others do) and would offer a route for philanthropists, trust and corporates to be involved in something more specific and personal than some of the larger instruments. It could also work closely with partners to develop other alternative funding mechanisms to work within the ecosystem of sustainable domestic financing for mental health.

6.4.4 Recipient Benefits

A fund of this sort would offer unpredictable capital flow so would either have to be regarded as “top-up” money, or used to specifically fundraise for one-off crises, emergencies or for mental health innovations and projects that would attract the attention of donors, corporates and philanthropists willing to donate early stage capital.

6.4.5 Precedent

The multi-donor fund (MDF) for Aceh and Nias was successful in mobilising several smaller donors, many of which joined an MDF for the first time. For smaller donors, such as Ireland and New Zealand, the MDF offered a ‘seat at the policy table’ and more access to senior policymakers than they would have had if they had donated bilaterally. The MDF still had a large financial stakeholder in the MDF, (the EU in this case) whereas it was less appealing to some other large donors, opening the door to a coalition of smaller donors. Another example is the Global Fund’s work with Lombard Odier to launch a strategic partnership to create ways to help the private sector contribute to the Global Fund’s work, while addressing investors’ need to meet their financial goals. The partnership looks at structures that allow investors to share a proportion of the gains they receive from putting their capital to work.
### 6.5 Financing Mechanisms: Options Summary

**Table 6: Comparison of Financing Mechanisms**

<table>
<thead>
<tr>
<th>Financing Mechanism</th>
<th>Precisely What?</th>
<th>Type of intervention it could support?</th>
<th>Who could it support?</th>
<th>Political Feasibility</th>
<th>Domestic Resource Mobilisation?</th>
</tr>
</thead>
<tbody>
<tr>
<td>International Finance Facility (IFF) for Mental Health</td>
<td>Critical mass of loan-based financing to provide predictable funding for major mental health reforms</td>
<td>Infrastructure (incl training), advocacy and emergencies</td>
<td>One implementing agency, i.e. the equivalent of a Gavi for IFFIm</td>
<td>Requires a champion i.e. a donor and implementing agency</td>
<td>Potentially</td>
</tr>
<tr>
<td>Mental Health Capital Account</td>
<td>Long-term, predictable and sustainable funding opening ways for different donors to commit.</td>
<td>Up-scaled mental health services</td>
<td>Range of agencies or government</td>
<td>Reasonable as using donor balance sheet rather than cash</td>
<td>Could make receipt of funds conditional</td>
</tr>
<tr>
<td>Mental Health Guarantee Facility</td>
<td>Donor guarantees increase the quantum or concessionality of funding available to LMICs</td>
<td>Infrastructure</td>
<td>Recipient Governments</td>
<td>Doesn’t require additional donor capital, established precedent</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Health Giving Pledge</td>
<td>Allows smaller funders and donors to support mental health in a more personal and controlled way</td>
<td>Depends, but crises, emergencies innovations and specific projects</td>
<td>Depends</td>
<td>High</td>
<td>Could make receipt of funds conditional</td>
</tr>
<tr>
<td>Status Quo i.e. existing mechanisms</td>
<td>Multiple ways to channel funds</td>
<td>Covers multiple different issues but more need to be directed to service delivery relative to research</td>
<td>Range of donors</td>
<td>To date calls for increases in funding through existing channels have not raised sufficient funds</td>
<td>Yes but to date has failed to substantially accelerate domestic investment</td>
</tr>
</tbody>
</table>

### 6.6 Conclusions

This section has provided analysis on how best to increase funding for different mental health activities by looking at the most appropriate financing model according to the funding profile of action required. To illustrate this in simple terms, Table 6 demonstrates an illustrative example of how each action package could be matched to the most appropriate financing mechanism(s) to help raise funds for each LMIC according to their current needs. This assumes that any mechanism will build on existing domestic and external financing, and be country-led. Table 7 illustrates how these action packages can be matched to the proposed financing mechanisms.
### Table 7: Illustrative matching of Action Packages and Financing Mechanisms

<table>
<thead>
<tr>
<th>Action Package</th>
<th>Action Package description</th>
<th>Financing Mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Focus on advocacy</strong></td>
<td>Influence government attitude to mental health, stimulate mental health leadership, &quot;open the door&quot; to further work</td>
<td>Mental Health Giving Pledge; International Finance Facility (IFF) for Mental Health</td>
</tr>
<tr>
<td>2. <strong>Demos and pilots</strong></td>
<td>Provide funds and expertise to run well-tracked pilots, and advocate for movement to scaled transformation</td>
<td>Mental Health Giving Pledge</td>
</tr>
<tr>
<td>3. <strong>Health and community system transformation</strong></td>
<td>Provide funds and expertise to transform the mental healthcare system, at scale</td>
<td>Mental Health Guarantee Facility; Mental Health Capital Account; International Finance Facility (IFF) for Mental Health</td>
</tr>
<tr>
<td>4. <strong>Focus on technical support</strong></td>
<td>Provide technical expertise to accelerate transformation</td>
<td>Mental Health Guarantee Facility; Mental Health Capital Account; IFF for Mental Health</td>
</tr>
<tr>
<td>5. <strong>Crisis</strong></td>
<td>Provide essential emergency mental health and psychosocial support, as well as fund transformation and scaling of care</td>
<td>Mental Health Giving Pledge; International Finance Facility (IFF) for Mental Health</td>
</tr>
<tr>
<td>6. <strong>Funding for innovation and cross Geography assets</strong></td>
<td>Create assets that could be used in many countries; create of central capacity; provide &quot;accelerator&quot;-type funding for promising projects</td>
<td>Mental Health Giving Pledge; International Finance Facility (IFF) for Mental Health</td>
</tr>
</tbody>
</table>

### 7 Structural options for GMH financing

At this stage we do not believe it would be efficient or make sense for a mental health financing mechanism to attempt to implement or administer funds itself. Accountability is another key reason to separate the financing mechanism from the implementation mechanism. Therefore, it is anticipated that funds will be largely allocated to existing institutions and actors, guided in these allocations by a set of Engagement Principles, with recipients responsible for reporting back to the funding mechanism.
The purpose of this paper is not to recommend a specific organisation to manage the funds generated. However, in the course of the consultation a set of engagement principles have been proposed. To encourage innovation and the broadest possible chances of financing impact, the sourcing of opportunities would be demand-based through open applications where appropriate. This preserves flexibility for the mechanism, but also places a responsibility in terms of judgement and capacity. This structure and its management seeks to maximise the efficiency of the financing mechanisms operations to ensure funds are used predominantly in delivering impact, rather than in unnecessary duplicative administration.

7.1 Engagement Principles

There is a danger that by being too prescriptive with how the financing mechanism disburses funds for implementation would hinder its ability to adapt to the vast range of countries, circumstances and changing market information. Therefore, rather than define specific projects, funds for implementation could be disbursed according to a set of “Engagement Principles” which would govern the activities of the instrument. These principles are outlined below based on existing literature and feedback from a range of experts and organisations. Again they are not meant to be prescriptive, and although somewhat binary in nature, there would need to be some flexibility as they are developed to offer ensure a robust, fair and transparent guide to funding eligibility.

7.1.1 The financing mechanism(s) will target funding towards LMICs

LMICs present the highest needs (e.g. the most vulnerable people due to poverty, disease and conflict) and the lowest amount of investments (i.e. the spending on mental health service delivery is the lowest). Although LMICs are developing quickly and are increasingly able to finance their own health needs, they often lack the budget capacity to prioritise mental health against competing demands. In addition, countries that graduate from LIC to LMC status are particularly vulnerable as they lose access to some or all their concessional financing. Concurrently it will be important to maintain the message that global mental health is for all countries (all are developing in terms of mental health) to ensure HIC engagement i.e. it is also good for them, and effective two-way knowledge exchange.

7.1.2 The financing mechanism(s) will mobilise additional funds for mental health

It will complement, not replace or displace, existing mental health financing by filling gaps and working towards mental health system transformation that allows recipient countries to refocus mental health spending away from existing institution-based and other services that have been proven to be ineffective. External financing must augment, not displace, existing domestic financing for mental health, and recipient governments must be incentivised to increase mental health spending gradually as they benefit from the health dividend, towards a sustainable mental health ecosystem beyond 2030.

7.1.3 Leveraging mental health expertise, funding, resources and implementation partners

Much has been achieved already in the mental health world and we need to learn from existing structures and initiatives, and work in a collaborative and complementary way to existing funding, develop and execute outreach strategy for existing and new partnerships. Encouraging innovation is important to help accelerate efforts to deliver better services, for example ‘Every Woman Every Child’ includes the innovation market place as a way of selecting and brokering the best interventions for investment.

7.1.4 Partnerships and collaboration with multiple mental health stakeholders
The only way to even begin to tackle the mental health challenge is by working together. However the proliferation of actors involved in DAMH has exacerbated the problem of coordination among them. Whilst important to respect a recipient country governments’ primary responsibilities for their citizens, it will also be important to engage civil society, the private sector, communities, technical partners, other health sector stakeholders, donors and other funders. All those involved in the mental health response should be involved in the decision-making process, including where ever possible promoting the involvement and wellbeing of people with mental health conditions.

7.1.5 Allocation and dispersal processes must be country-led and country-specific, not add an administrative burden and promote genuine local knowledge and expertise.

In order to strengthen health systems, implementation must be ‘owned’ by individual recipient countries, with the central government as the main counter-part. Country-level responses should be tailored by the political and cultural context, existing programmes and initiatives, and likely absorption and implementer capacity. It will be important to minimise the administrative burden associated with scaling up mental health service delivery. Dispersal must involve more than competitive tender and should have easy to use formats, process and grants management approach to promote genuine local knowledge over expert proposal-writing. There must be an element of capacity building of networks of and organisations working in and for the mental health sector and assuring funds are going to the right place first.

7.1.6 Transparent governance, processes and activities

The financing mechanisms and disbursement processes must operate with the highest degree of transparency and professionalism, including applications for funding, funding decisions, financial accountability, grant performance, implementation decisions, monitoring and evaluation, governance and oversight. The instrument must also support and participate in the International Aid Transparency Initiative. Eligibility criteria (for funding support) must be transparent, efficient and have clear reporting and evaluation processes. The input of people with lived experience will be important to provide expert input into what is scaled, and ensure accountability for how funds are spent.

7.1.7 Sustainability of interventions and measuring impact

Whatever option(s) are taken forward by the mental health community, the approach must be to ensure any new structures, mechanisms, processes and interventions are evidence-based, efficient, affordable, scalable, and sustainable. We must ensure that what is paid for by the funds represents the most cost-effective option for that setting, and is based on the latest evidence. Wherever possible they should complement existing mental health instruments and agencies, learn from previous initiatives and work in coordination with existing enterprises to fill acknowledged gaps. Establishing robust and transparent measurable impact metrics will be critical. We will need to ensure a mechanism for evaluating the impact that the funding is having, and learn lessons from the implementation to improve future efforts. We need to ensure that the financing mechanisms not only include these structures, but also will pay for the impact assessments, knowledge synthesis, and support during different stages of the implementation process from testing to transition to scale to determine what to implement. MHIN could be one starting point for this, similar to the EWEC marketplace.

7.2 Hosting Options

At this stage we do not believe it would be efficient for a global mental health financing mechanism to attempt to implement or administer funds itself. Therefore, it is anticipated that funds will be largely allocated to existing institutions and actors, guided by the Engagement Principles above. However in
terms of governance the financing mechanism(s) will need to be ‘hosted’, with the following options to choose from:

7.2.1 Hosted Entity: Trust Fund or FIF hosted by the World Bank

As a hosted entity, one option for an implementing agency would be the World Bank. There are two existing structures for the receipt of additional funds into the World Bank – a Financial Intermediary Fund (FIF), and a Trust Fund. Categorized as a subset of the WBG’s Trust Fund portfolio, and larger than Trust Funds, FIFs are financial arrangements that leverage a variety of resources, typically in support of one global priority. They are managed by external agencies providing funds, and the WBG provides a set of agreed financial services that involve receiving, holding and transferring contributed funds when instructed by the FIF governing body. Trust Funds are a second type of WBG institutional arrangement, whereby the WBG provides Trustee services, which can be used to finance a wide range of projects and activities (e.g. the Global Financing Facility). The WBG’s role and responsibilities in managing Trust Funds varies depending on the type of fund, but includes structural options whereby the WBG is responsible for controlling the allocation of funds under the mandate.

- **Advantages.** Suited to offer a range of instruments. To be hosted as an FIF by the WBG allows for outsourcing of key operational functions including treasury services (including foreign exchange management), donor contribution management, accounting, disbursements and reporting to the World Bank at comparable low costs (cost recovery-basis, no fees). For capital market instruments, the entity could tap into the WBG’s network and leverage its rating, creditor status and well-established investor network.

- **Disadvantages.** Exposure to criticism of World Bank path dependency, and trusteeship does not include oversight or supervision of the use of funds (the latter only of concern for institutions with an implementation mandate).

- **Suitability for mental health mechanism(s).** Possible options for mechanisms under Trust Fund/ FIF structures include: capital market instruments. grant mechanisms; debt relief (e.g. Debt2Health for GFATM), Social Impact Bonds (SIBs) or Development Impact Bonds (DIBs).

- **Precedent.** Examples of FIFs include GFATM and IFFIm, and the Coalition for Epidemic Preparedness Innovations (CEPI) is structured as an FIF. Examples of Trust Funds include GFF.

7.2.2 Separate Entity: Own board hosted under UNOPS

As a separate entity hosted under United Nations Office for Project Services (UNOPS), i.e. with UNOPS hosting the secretariat and providing back-office services for Financial Management activities, the entity would be integrated into the wider UN System and be able to tap its broad network and presence in nearly every country. As an agency specialised in grant management, monitoring and procurement procedures, UNOPS can be considered a preferable service provider for a globally active grant-making entity with an implementation mandate. To assess the aptness and suitability of a hosting arrangement under UNOPS it will be necessary to first agree the type of funding the entity wants to raise and through what mechanism e.g. for an IFFIm-type front-loading of donor pledges through bond issues in the capital markets UNOPS would be less preferable as there is currently no precedence of such a UNOPS-hosted entity.

- **Advantages.** Integrated into UN System, UNOPS’s broad network and presence in nearly every country; beneficial for initiatives, to which UN agencies are key stakeholders; specialised support for grant and procurement procedures; proven host for entities such as StopTB, which manages three grant-based financing facilities, and has the ability to monitor
programmes on the ground, so suitable for implementing agencies; can provide limited direct management (back office) support.

- **Disadvantages.** Financial Management by UNOPS currently has no known precedence for managing securities or capital market products; limited expertise in Debt Fund management and Fund investment (limited activity in capital markets); 7% management fees.

- **Suitability for mental health mechanism(s).** Would need to manage capital market instruments (where applicable) separately; no specialisation within UNOPS for arrangement or outcome funding for results-based instruments such as SIBs or DIBs, however, support to DIB/SIB through grant funding for TAF possible.

- **Precedent.** Stop TB Partnership; RBM (Global Platform for Coordinated Action Against Malaria/ Roll Back Malaria) 117.

### 7.2.3 Hosted Entity: Under a University or Research Institute

An entity hosted by a research or higher education facility such as Amazing Minds Africa or the Brown University’s Global Health Initiative (GHI) would primarily offer the benefit of being perceived as independent and non-political, whilst working closely with scientific experts in the field. While this can be beneficial for some purposes, it also harbours the risk that donors would perceive an entity as driven or committed only to research, rather than the full spectrum of activities required from fund raising, management, allocation for service delivery etc. A hosting arrangement through a university would therefore likely require contracting of external financial management services.

- **Advantages.** Credibility as non-political, non-“Northern-led” facility in LMICs; close alignment with scientific/academic experts; suitable for advocacy groups; suitable for types of grant disbursements (scholarships, technical assistance).

- **Disadvantages.** Dependence on the institute’s frameworks; perception of a research-focused entity; potential lack of institutional capacity for financial/funds management, and further, universities may even be prohibited from hosting an entity of this type according to their investment policies; choice of hosting department may limit multi-disciplinary approach; no known precedent of “financing-only” institution under a university; lack of a network of development partners such as the one offered by the UN or WBG; potential conflict of interest.

- **Suitability for mental health mechanism(s).** Would need to manage debt funding (where applicable) separately; very few universities experienced in arrangement and/or outcome funding for results-based instruments such as SIBs or DIBs, however, support to DIB/SIB through grant funding for TAF possible.

- **Precedent.** Amazing Minds Africa, Brown University Global Health Initiative (GHI), both of which are advocacy entities, which receive donor fund for operational activities, and are not providing funding for external entities. Grand Challenges Canada (GCC) is hosted in Toronto at the Sandra Rotman Centre at the University Health Network.

### 7.2.4 Stand-alone Entity: A New Financing Institution

A new institution could be created to host the financing mechanisms as part of it. Theoretically this could offer a range of freedoms in terms of domicile/location, organisational structure and/or policies, However, practical options are likely to be limited by donor requirements. If the entity is to be funded primarily through donor commitments, the legal form of a charitable non-profit organisation will be a recommendable option due to the regulation for tax breaks among other reasons. Further, the entity will need to generate its internal policies and principles under consideration of target donors’ funding requirements (e.g. allocation of funds could be restricted to...
exclude certain countries or programme areas). This could undermine the potential for the financing mechanism, under an independent institution, to be politically neutral and to respond to those areas of greatest need. To further assess the adequacy of an independent structure, it would need to be decided what instruments will be used to raise and disburse funds under such an entity in order to assess what fund management services would be required.

- **Advantages.** Credibility as non-political, ‘non-Northern-led’ facility in LMICs; freedom in choice of location/domicile, structures (and respective policies theoretically); however, as an entity to be funded through government donor commitments, a charitable non-profit is the default option to be eligible for tax breaks.

- **Disadvantages.** Requires consultants (or comprehensive financial management services) to perform fund and stakeholder management structures and in-house expertise to oversee the work i.e. the raise, hold, transfer, investment of funds; no standing/rating/network or experience to structure or advise on debt instruments; higher start-up (set up of new fund) and operational costs (contract fund managers); high dependency on ongoing donor support; domicile and governing policies (e.g. SDG alignment etc.) likely driven by donor preferences.

- **Suitability for mental health mechanism(s).** Not suitable for instruments that require a credit-rating; utilization of charitable bonds is possible, although feasibility will depend on relationship with and commitments from dedicated trusts and philanthropists versed in charitable bond investments (in mental health).

- **Precedent.** Global Campaign for Education; GAIN (Global Alliance for Improved Nutrition)118

### 7.3 Conclusions

As shown above, different hosting options will imply different organisational requirements and provide benefits for different financial modalities. Depending on the purpose of the entity i.e. whether it seeks to fundraise from new investors and/or donors to the sector, or whether it seeks to increase allocation of existing funds in target countries for mental health (or a combination thereof) the decision will have to be made if the entity will require a financing facility. In order to set up a financing facility, the entity will need to seek clarity on a number of groundwork questions including what funding the entity will seek to raise, how it plans to manage it, how to disburse it, and the timeframe under which it will operate. This will be subject to further work once clarity around the likely financing mechanisms.

Generally speaking, if the entity seeks to increase the allocation of existing funds in the sector towards mental health through building a partnership of various stakeholders (including for example private sector entities, development banks and researchers) that will support national authorities through advice and grants, an arrangement with UNOPS will provide a range of benefits over a stand-alone or a university-hosted entity. The latter two options, however, are recommendable for advocacy entities with simple governance structures and low operational costs (as is the case if for example the entity does not disburse grant funds).

If the entity arrives at the conclusion that a set-up of a new financing facility, that will allow for the utilisation of more complex and non-grant financial instruments, an arrangement of a Trust Fund or Financial Intermediary Fund (FIF) under the World Bank is the recommended option, as key treasury, investment and general financial management services could be outsourced to the WBG, leveraging their credit rating and investor network.
8 Proposed Plan

We are entering an era of major transition for global mental health. This paper offers an overview of the existing financing landscape in mental health and options to increase funding to global mental health on an unprecedented scale. To reach that goal, new sources of funding will be needed to compensate for that not being met through traditional financing means.

We will need a well-defined strategy for engagement and advocacy to target and maximise the opportunities at global institutions and events. We will need a clear and realistic proposal of who and where will be funded, and with what measurable impact, that we can sell to the wider world, donors and recipient countries. Accountability will be key. We will also need to use different ‘entry points’ as we cannot afford to lose any opportunity to put the mental health agenda within broader fora, or to leverage additional funding where cross-overs exist.

Although a homogenous view of LMICs was taken to establish the funding baseline, very solid country-level consultations will be required to establish how different action plans/interventions may require different kinds of mechanism. We will need to be realistic about timing and not raise expectations. Although recipient governments should remain the main interlocuters, consultations and engagement should embrace non-state actors such as civil society, the private sector and local communities to gain a proper understanding of what interventions will be effective, and how to implement them.

8.1 Recommended Approach

8.1.1 Introduction

The fundamental means to increase funding for mental health is for national governments to increase their spending; this is critical to complementing external funding, and arguably the most sustainable means to ensure service delivery. However, in the absence of sufficient domestic funding for LMICs, this paper has proposed two basic models to accelerate increased external funding for global mental health:

- Secure greater funding through existing channels, leveraging a greater number of ‘entry points’, incentivising domestic resource mobilisation and the proposed Trust Fund for NCDs.
- Develop a new financing mechanism(s) to encourage more funding for mental health that would be disbursed through either existing or new organisation(s).

This paper recommends that to secure the quantum of financing (US$19 billion over 10 years) needed to scale up mental health service delivery in LMICs, both are needed. It will take time to secure agreement from potential donors and recipients on the design and governance of any new financing mechanism. In the short term greater funding will have to be found through existing channels (albeit ideally increased through more effective advocacy and better use of ‘entry points’). In the medium-to-longer term a new financing mechanism(s) may unlock funding from new sources and/or in greater volumes than are possible through existing channels. But to be clear, without the latter, mental health in LMICs will struggle to receive the prioritisation it needs to have any meaningful impact by rising above the US$1 pppa figure that has already been described as inadequate.

8.1.2 Recommendations:

There have been many papers on global mental health financing and many recommendations made. The following focus on the conclusions of this paper:
Recommendation 1: National governments need to step up now to the challenge of delivering mental health services and financing them in accordance with the overall principle of UHC. They must meet the targets they have collectively agreed including achievement of the SDGs. External funders, particularly those committed to improving health in LMICs, should prioritise and increase the amount of funding that is spent on mental health. DAMH is pitifully low and must increase if the health and other SDGs, are to be met. Parity between mental and physical health should be the overarching vision, and needs to be recognised by all, including those providing often substantial proportions of LMICs’ health budgets and financing for the provision of health services and emergency health care.

Recommendation 2: To accelerate funding for mental health, financing mechanisms are required over and above the status quo. Responsibility for rapidly increasing financing for mental health has to move beyond discussion among the mental health community, to action by national governments, and those donors who want to support them, to deliver mental health services to their citizens. Swift action to implement at least one innovative financing mechanism will help accelerate the rise in funding needs for mental health in LMICs.

Recommendation 3: National governments should use gatherings of health ministers and/or finance ministers to explore ways to rapidly increase funding for mental health through collective and individual action. They should pledge their support to doing so in joint statements such as at the upcoming summit in the UK on Mental Health and Wellbeing and in the development and ratification of the next WHO MHAP. Their progress towards financing national mental health plans should continue to be monitored through the Mental Health Atlas. This will require continued strong advocacy and support from the wider mental health community, and evidence provided to those who might not deem it a sufficiently high priority when weighed against competing demands.

Recommendation 4: The WHO and other leading health partners should encourage discussions on financing for UHC and for NCDs to include and promote financing for global mental health. Similarly, those involved in shaping funding discussions related to the other ‘entry points’ identified in this paper and elsewhere, should include financing for mental health.

Recommendation 5: Trusts and Foundations with an interest in financing global mental health should: look to increase the funds they invest and encourage others to do so; examine whether they could be part of a better coordinated group of donors that backs the establishment of a new financing mechanism(s), much needed across all donor types (as with the research community); and see how they can best influence the policies surrounding existing channels of funding and how they could support the development of new financing mechanism(s).

Recommendation 6: Civil society should look at how they can best influence the policies surrounding existing channels of funding and how they could support the development of new financing mechanism(s) and be part of the governance of those mechanism(s) to increase financing for mental health. There needs to be greater coordination among civil society to maintain strong, consistent ‘one-voice’ advocacy to maintain existing spend, and encourage the re-prioritisation of spending towards mental health. Civil society also has a critical role to play in the ensuring the accountability of all funders for mental health: particularly to those with lived experience.

Recommendation 7: To improve the effectiveness and efficiency of mental health activities, all those seeking to fund work in mental health need to increase transparency in order to
better track and coordinate financing for mental health. The emphasis should be on scaling up
effective solutions, based on evidence of what works, and on increasing the longevity of
funding to ensure sustainable service provision.

- **Recommendation 8:** Integrating up scaled mental health services within existing systems of
care (e.g., primary care clinics, communities, NGOs, schools) is the single action most likely to
highly impact mental health in LMICs and maximise the efficiency of resource investments.
We must ensure that implementation is based on the best evidence, and the impact of the
investment evaluated in a standardised way, with results used to improve future investments
based on evaluation of effectiveness and cost-effectiveness. Additional funding will be
required through existing ‘entry points’ and new financing mechanism(s) to fund this work.

### 8.2 Next Steps

The global mental health community already has the means to hold governments to account for their
leadership, financing and evaluation of mental health activities. Through the regular reviews of
progress against the MHAP (especially the WHO Mental Health Atlas) and the SDGs, governments can
be held to account. The recent Mental Health Atlas and the forthcoming country profiles are critical
sources of information; and the mental health community has an enormous wealth of experience and
knowledge with which to effectively advocate for increased financing and political action, including a
strong evidence base from DCP-3 and other sources on ‘what works’. Moreover, the global mental
health community can, and should, come together to persuade national governments and those
wishing to support them financially, to advocate for more funding for mental health. Ideally, this will
be achieved through coordinated national and global level advocacy involving all those who are
committed to accelerating progress, particularly in LMICs where the need is greatest.

The GCFMH commissioned LHGP to produce this paper. The next step will be the GCFMH and LHGP to
discuss its findings and the best means for implementation of the recommendations outlined. Phase 3
of this work - to develop potential financing mechanism(s) in more detail and at the same time begin
work to accelerate funding for global mental health through existing channels – will then need to
begin in short order. Without a significant increase in action to increase funding for global mental
health in the next 12-18 months the SDGs and the detailed targets of the MHAP will not be met, and
the momentum created by the new Lancet Commission report will be lost.
9 Contributors

Lions Head Global Partners would like to thank all those who have contributed to this paper. Beyond the enormous wealth of material we were able to draw upon from the many documents cited in the end notes, the following people and organisations have provided specific inputs to this paper: WHO (Mark Van Ommeren and Dan Chisholm); WBG (Tim Evans and Patricio Marquez); UNSG Office (Taona Kuo and Trey Watkins), UN Special Envoy’s Office (Alan Court); Brad Herbert Associates (Brad Herbert); Kings College London (Professor Sir Graham Thornicroft); Cities Rise (Pete McDermott); Harvard University (Vikram Patel, Shekhar Saxena, Arthur Kleinman and Daniel Vigo); LSHTM and CBM (Julian Eaton); SA Federation for Mental Health and Movement for GMH (Charlene Sunkel); Wellcome Trust (Mary De Silva); World Economic Forum; WEF (Vanessa Candeias); CIFF (Taryn Barker); Amazing Minds Africa (Samuel Talam); London School of Economics and Political Science (Valentina Iemmi); GCFMH (Sarah Kline, Christie Kesner and Elisha London); The Boston Consulting Group (Johannes Thomas); other National mental health stakeholders.

This paper was funded by GCFMH, but the conclusions are independent, and may not necessarily reflect the views of GCFMH.
Endnotes

1. Goffman, 1963
2. Thornicroft et al., 2008
5. http://www.who.int/social_determinants/themes/civilsociety
6. 2017 WHO Mental Health Atlas
8. The Health, Nutrition and Population Global Practice at the WBG.
9. The 2018 Lancet Commission on Global Mental Health & Sustainable Development
10. While the private sector is an important player in mental health, its role in potentially directly providing funding for mental health services is not included in this paper: the assumption is wherever possible mental health services will be provided according to the Universal Health Coverage principle of being free at the point of delivery. The private sector is included in terms of investment through financing mechanisms.
35. Ibid
40. WHO 2017 Mental Health Atlas
45. Thornicroft et al


54 To give an idea of the magnitude the total global development aid across all sectors in 2016 reached an all-time peak of US$142.6 billion, an increase of 8.9% from 2015 after adjustment for exchange rates and inflation.


57 The World Bank Group and WHO co-hosted the "Out of the Shadows: Making Mental Health a Global Priority" in Washington DC as part of the WBG-IMF Spring Meetings.


59 See the BCG "LMIC Financing Mechanism" report for more details on the country groups, how the criteria were defined, and metrics they were based on. It is acknowledged that like LMIC classifications (done annually) the country classification may change in the future, and it may be necessary to replicate the initial exercise periodically (e.g. annually or every few years). Country groups were defined using a mix of expert input and data: Income and disease burden (GDP/capita, WB income classification, DALYs), Capacity (predominantly qualitative expert input), political will (predominantly based on WHO Mental Health Atlas, health and mental health expenditure), c0risis level (WHO public health crisis grading).

60 Closer to implementation, action packages would need to be developed into a much greater level of detail. This could leverage work done for the DCP-3 volume on mental health, e.g. as summarised in Patel, V. et al. (2015), "Addressing the burden of mental, neurological, and substance use disorders: key messages from Disease Control Priorities, 3rd edition", The Lancet 387 (10,028), pp. 1672-85.

61 See WHO priorities: http://www.who.int/dg/priorities/en/


Development assistance for health (DAH) refers to financial and in-kind resources that are transferred from development agencies (such as UNICEF or the United Kingdom’s Department for International Development) to low- and middle-income countries with the primary purpose of maintaining or improving health. DAH is mutually exclusive from out-of-pocket, prepaid private, and government health spending. See http://www.healthdata.org/sites/default/files/files/policy_report/FGH/2017/IHME_FGH2016_Policy-Report.pdf


These fellowships provide training to journalists to support reporting on topics related to mental health and substance use issues.

Pollitt, Alexandra, Gavin Cochrane, Anne Kirtley, Joachim Krapels, Vincent Larivièrè, Catherine A. Lichten, Sarah Parks, and Steven Wooding, Project Ecosystem: Mapping the global mental health research funding system. Santa Monica, CA: RAND Corporation, 2016

US$0.02 is the 2017 Mental Health Atlas estimate of government mental health expenditure only, and based on a small sample of responding countries. US$0.20 is the average you get when you multiply total health spending in each LIC by 0.5% (an estimate of the % of THE on mental health). See Appendix B of the ODI 2016 report on investing in mental health for details.

ODI Report ‘Investing in Mental Health in low Income Countries’.


2018 World Bank figures. For the current 2018 fiscal year, low-income economies are defined as those with a GNI per capita, calculated using the World Bank Atlas method, of US$1,005 or less in 2016; lower middle-income economies are those with a GNI per capita between US$1,006 and US$3,955.

The ODI Insights Report “Investing in Mental Health in LICs” dated December 2016 recognised the benefit of increasing spending gradually reflecting the time required to increase health system capacity as mental health system investment begins to yield returns and in-country capacity increases.

It is assumed that the current WHO Mental Health Action Plan 2013-20 will be superseded before 2020 by a new iteration. The Financing Mechanism workstream offers a useful opportunity to shape the next Action Plan for the next era, especially in terms of the intervention packages the US$1, US$2 and US$3 pppa graduated approach across LMICs between 2020-30 would fulfil.
It is important to note that although DAH for NCDs rose rapidly during 20010–2016, it is the health focus area with the smallest amount of funding, by far, compared with other areas; in 2016 it still only represented 1.7% of total DAH. In 2016, the main channels of assistance for NCD funding were NGOs and WHO. Funding has increased for NCDs 9.5% annually, on average, since 2000, whilst support for mental health programs has increased 4.9% annually from 2000.


“This compares with an estimated US$37·4 billion of development assistance disbursed for health in 2017, of which US$9·1 billion (24·2%) targeted HIV/AIDS” Global Burden of Disease Health Financing Collaborator Network “Spending on health and HIV/AIDS: domestic health spending and development assistance in 188 countries, 1995–2015”, published 17 April 2018


The disability sector has a funding mechanism called the Disability Empowerment Concerns Trust, established in 1996 by major South African national NGOs representing people with disabilities, where these six beneficiary organisations (national NGOs) receive proceeds from large investments. http://www.dectrust.co.za/


WHO (2018), Time to Deliver: report of the WHO Independent High-Level Commission on Noncommunicable Diseases, World Health Organization, Geneva, Switzerland. “WHO should prioritize NCDs and mental health. This requires that Member States consider increasing or reallocating their contributions to the organization so that WHO can meet the demand for country support. Support for addressing NCDs is the leading request from countries, but the Organization’s budget has been reduced in the current biennium owing to lack of financing from donors”


Feedback includes from Samuel Talam, June 2018.


ODI Insight Report "Investing in Mental Health in low-income countries"


WHO (2018), Time to Deliver: report of the WHO Independent High-Level Commission on Noncommunicable Diseases, World Health Organization, Geneva, Switzerland

See Nurturing Care for Early Childhood Development, a framework for helping children survive and thrive to transform health and human potential, ISBN 978-92-4-151406-4 2018

Chisholm et al 2016b

Chisholm et al 2016b

LMIC Financing Mechanism dated 05/04/18

Feedback from Daniel Vigo, Harvard University, June 2018.

Feedback includes from Samuel Talam, Amazing Minds Africa; Global Movement for Mental Health, June 2018.

The Every Woman Every Child Innovation Marketplace is a strategic alliance of development innovation organizations including the Bill and Melinda Gates Foundation, Grand Challenges Canada, the United States Agency for International Development, the Norwegian Agency for Development Cooperation and UBS Optimus Foundation. The Marketplace is hosted at Grand Challenges Canada.

For example, the recently launched Coalition for Epidemic Preparedness Innovations (CEPI) is structured as an FIF, as is the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) or the International Finance Facility for Immunization (IFFIm). The GFATM has channelled almost US$40 billion to fight infectious diseases from a range of donors.

See https://www.brookings.edu/wp-content/uploads/2015/07/impact-bondsweb.pdf. Note that the current market for SIBs/DIBs is limited in value in terms of beneficiaries reached (max 10K, most smaller than 1K) and capita moved (max US$24M, most smaller than $5M). These bonds also have high transaction costs and can transfer undesirable risk to service providers, usually non-profit organisations, since failure to deliver promised results means the end payer is not obliged to provide funding.

It is important to highlight that both entities are at their core advocacy platforms/ social movements, which fund themselves through donor commitments and provide grant-based funding to civil society groups for advocacy work only.

Originally designed as an initiative within the Bill and Melinda Gates Foundation (BMGF) in 2000, GAIN was established in 2002 as an entity under the UN System with initial funding from BMGF, USAID, CIDA, and only became an independent NGO in 2005.