

The background of the cover features a large, diverse crowd of people, seen from an aerial perspective, arranged to form the geographical outline of the world map. The crowd is composed of individuals of various ages, ethnicities, and clothing, creating a vibrant and inclusive visual. The background color transitions from a deep purple at the top to a bright blue at the bottom. In the bottom left corner, there is a network diagram consisting of interconnected blue circles and lines, symbolizing global connectivity. The title 'FINANCING MENTAL HEALTH FOR ALL' is centered over the world map in large, white, bold, sans-serif capital letters. Below the title, the text 'UHC POLICY BRIEF SERIES' is also centered in a smaller, white, bold, sans-serif font. In the bottom right corner, the United Nations logo is partially visible, followed by the text 'UNITED FOR GLOBAL MENTAL HEALTH' in white, bold, sans-serif capital letters.

FINANCING MENTAL HEALTH FOR ALL

UHC POLICY BRIEF SERIES

UNITED
FOR
GLOBAL
MENTAL
HEALTH

“The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”

The Constitution of the World Health Organisation

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EXECUTIVE SUMMARY

The concept of universal health coverage (UHC) originated in the World Health Organisation constitution of 1948. It means that everyone, everywhere should be able to access the health services they need without suffering financial hardship. The WHO constitution defines health as a state of complete physical, mental and social well-being, and not merely the absence of disease and infirmity.

“The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.” – The WHO constitution

The reality, however, is that there’s a huge gap in the global coverage of care for mental health conditions – as wide as 90% in some low-income countries – and too often, the care that is available is disproportionately focused on tertiary or secondary rather than primary health care (PHC) and community-based care.[i],[ii] As things stand, we are failing to uphold people’s right to the highest attainable standard of health, as initially set out in the WHO constitution. Median global government spending on mental health as a percentage of government health expenditure is only 2.1%. According to UNICEF’s State of the World’s Children report,[iii] only a small fraction of this expenditure goes to those most vulnerable, such as children, adolescents and caregivers. It is essential to address this coverage gap by integrating mental health into national UHC policies, plans and funding mechanisms, and by strengthening PHC, and community-based care and financing. Mental health is not separate from physical health. A holistic person-centred approach accounts for comorbidities, influences physical health outcomes and affects the overall costs of care.

This is the right time to advocate for integration, as UHC now has a prominent role in global discourse and planning on:

- **achieving the health-related Sustainable Development Goals**
- **health-system strengthening**
- **emergency – including pandemic – preparation, response and recovery**

The WHO’s Comprehensive Mental Health Action Plan 2013-2030 recommends integrating mental health into UHC. It sets member states the target of increasing their existing mental health service coverage by 50% by 2030, ‘away from long-stay mental hospitals towards non-specialised health settings’. [iv] Achieving this goal for five of the most prevalent mental health conditions (anxiety bipolar disorder, depression, epilepsy and psychosis) only requires a year-on-year increase of US\$0.2 in global per capita mental health investment until 2030.

This is well within the means of many governments, even those requiring external assistance. For low- and lower-middle-income countries, it would mean increasing year-on-year expenditure by US\$0.004 and US\$0.02 per capita respectively. This looks very low because for many countries the current coverage levels are very low, and financing is very small. Therefore a 50% increase in coverage and the associated increase in financing are modest, although the potential impact for individuals is considerable. Indeed, according to our research, steadily increasing global health financing to achieve this target between now and 2030 for the five mental health conditions examined in the research – anxiety, bipolar disorder, depression, epilepsy and psychosis – could result in some significant positive health outcomes: 23.9 million healthy life years gained, 51.5 million prevalent cases averted, and 478,000 deaths averted.

PRIMARY HEALTH CARE VS UNIVERSAL HEALTH COVERAGE

Some organisations focus on achieving UHC for all, while others focus on strengthening PHC in particular. In this briefing series, we focus on integrating mental health in UHC because this addresses the current gaps at tertiary, secondary and primary levels of health care. In many countries finance and other resources for mental health are concentrated on the tertiary level with facilitates such as mental hospitals.

The WHO and many others strongly recommend reversing the current practice of focusing most investment and services at tertiary level and instead prioritising primary health care (along with community-based care) to more effectively address the mental health needs of most people around the world. In other words, PHC and UHC are both important to achieving better mental health for all.

Achieving UHC for mental health must be the goal. This is, in line with the guiding vision of the SDGs and the realisation of the right of everyone, everywhere to good mental health.

As well as a 50% an increase in coverage, the research looked at the cost and health outcomes of achieving 50%, 80% and 90% coverage rates, either between 2022-2030, or between 2022-2025 – in total that's eight scenarios – all of which, with disaggregation by country income group, are detailed in annex 1. According to our research, steadily increasing global health financing to achieve UHC (90% coverage) between now and 2050 for the five mental health conditions examined in the research would result in some startlingly positive health outcomes: over 500 million healthy life years gained, over 6 million deaths prevented, and just under 1.5 billion cases of mental health conditions averted.

Achieving UHC would be very difficult, but as a mental health community it is essential that we consider all avenues and strive for its achievement.

The economic case for mental health coverage

There is a compelling economic case for this increase in mental health financing prioritised towards PHC and community-based care. The State of the World's Children report totals the annual cost for children and adolescents in terms of lost human capital of mental health conditions such as depression and anxiety, and the loss of lives to suicide as approximately US\$387billion. Conversely, the WHO[v] projects a return of US\$5 for every US\$1 spent on increasing coverage for common mental health conditions, thanks to productivity gains.

Financing the integration of mental health into UHC

This policy brief outlines three ways to finance the integration of mental health into UHC:

- 1) UHC financing: integrating mental health into UHC financing schemes
- 2) Cross-government financing: the integration of mental health into health and other relevant budgets across sectors; into medium-term budgetary frameworks; and into cross-government and national development plans
- 3) Integrating development assistance for mental health into existing emergency responses, development programmes and established financing mechanisms.

Closing the gap in mental health service coverage is necessary, achievable and beneficial. It is essential that mental health be integrated into UHC, particularly at PHC and community level, and underpinned by up-to-date laws, plans, strategies and budgets. To make this happen, the following actions must be prioritised:

- **Governments must commit adequate domestic finance to ensure that an essential package of mental health services is available to all, including particularly vulnerable groups such as children, adolescents and their caregivers, without causing financial hardship**
- **Governments must commit the resources necessary to increase mental health service coverage (with priority given to PHC and community-based care) by 50% by 2030 – the target set by the WHO's comprehensive mental health action plan (2013-2030)**

- **Domestic and international donors must support governments and civil society organisations to capitalise on the opportunities presented by the various global commitments and financing mechanisms related to integrating mental health in UHC**
- **International aid donors must commit to increase funding in development assistance in mental health (DAMH) to US\$1.9bn per year ^{vi}, and ensure DAMH is integrated into existing emergency responses, development programmes and established financing mechanisms.**

THE MENTAL HEALTH FINANCING LANDSCAPE

Eliminating the service coverage gap requires significant investment. Increased and improved finance is essential to:

- **integrate mental health services into primary, secondary and community-based healthcare**
- **train mental health professionals**
- **increase the capacity of mental health services**
- **reduce the stigma that surrounds mental ill health**
- **promote mental health and prevent mental health conditions**
- **ensure that wealth is never a barrier to accessing these services.**

The underfunding of mental health services affects both the supply of and demand for these services.^{vii} For example, it is likely to mean there's an inadequate supply of trained mental health professionals, and a lack of accessible care (particularly at PHC and community level). Without investment in education, the stigma surrounding mental health conditions may reduce demand

for the services that do exist. And without sufficient funds for promotion and prevention, more people are likely to develop mental health problems and require support.

Research commissioned by UnitedGMH using the WHO's One Health Tool (OHT)^{viii} and building on data from the WHO's Mental Health Atlas 2020^x and other sources found that the median 2022 global mental health government expenditure is projected to be US\$9.52 per capita. High-income countries account for a large proportion of this spending. In low-, lower-middle and upper-middle income countries, spending is projected at just US\$0.08, US\$0.37 and US\$3.29 respectively.

As a percentage of median domestic general government health expenditure, median global government expenditure on mental health only amounts to 1.68%. Low investment means high treatment gaps and lack of support. Studies have found treatment gaps of up to 90%^x for depression, anxiety and bipolar disorder in low-income countries, 88%^{xi} for psychosis and 86.9%^{xii} for epilepsy. Even in high-income countries, where spending is much higher, there is a 63.2% treatment gap for depression, anxiety and bipolar disorder in 2022. Furthermore, there remains a disproportionate focus on spending and policy on tertiary and secondary mental health services compared to PHC and community-based care, while vulnerable populations, including children and caregivers, remain underrepresented. Therefore, in every country in the world, there is still a long way to go.

Treatment coverage gaps can force people to resort to paying out of pocket for alternative or informal treatment methods,^{xiii} or to go without treatment altogether. When mental health services are not offered free of charge as part of PHC or incur travel costs to reach because of a lack of community-based care, many people are priced out of accessing them.^{xiv}

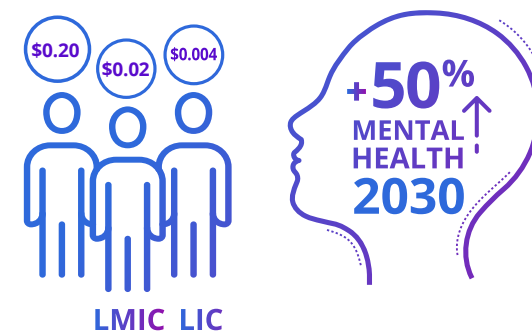
It would cost just US\$0.20 more per person each year until 2030 to increase the global coverage of essential mental health services by 50%

HOW MUCH INVESTMENT IS NEEDED?

New UnitedGMH-commissioned research conducted by Deakin University using the WHO's One Health Tool (OHT) reveals the investment required to meet WHO mental health service coverage targets for anxiety, depression, epilepsy, bipolar disorder, and psychosis ^{xv} - all of data for the eight scenarios modelled, with disaggregation by country income group, are detailed in annex 1. To ensure efficiency and quality of financing, it is recommended that in achieving these targets, priority be given to spending on PHC and community-based care rather than tertiary care settings.

Achieving the WHO's Comprehensive Mental Health Action Plan target figure for 2030

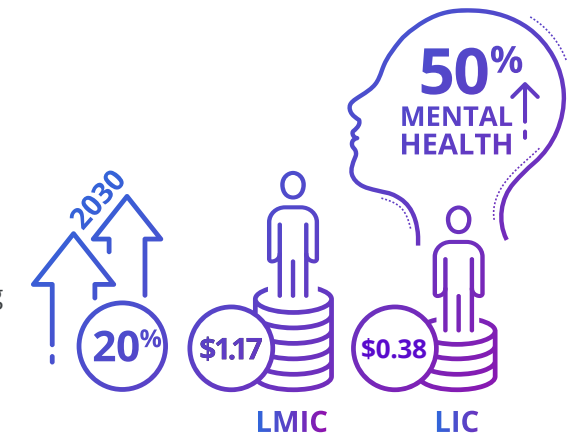
Closing the treatment gap may be more financially viable than assumed if funding is increased gradually. The WHO's Comprehensive Mental Health Action Plan 2013-2030 gives member states the target of increasing treatment coverage for the five conditions listed above by a further 50% of the existing coverage by 2030 'away from long-stay mental hospitals towards non-specialised health settings'. ^{xvi} Our research shows that would involve an annual increase in expenditure of approximately US\$0.20 per capita until 2030.



Low- and lower-middle-income countries would only need to spend an additional minimum of US\$0.004 and US\$0.02 per year per capita respectively to reach that target. This is a small increase in mental health expenditure that should be seen in the context of very low rates of mental health coverage and expenditure that already exist across many countries. As such, a 50% increase in service coverage represents modest progress. For example, mental health expenditure in 2022 among low-income countries is \$0.08 per capita, so increasing mental health coverage by 50% will involve boosting expenditure to just \$0.12 per capita by 2030. Therefore, if there is 10% treatment coverage of depression and anxiety in a country today, then raising this to 15% treatment coverage by 2030 will cost relatively little.

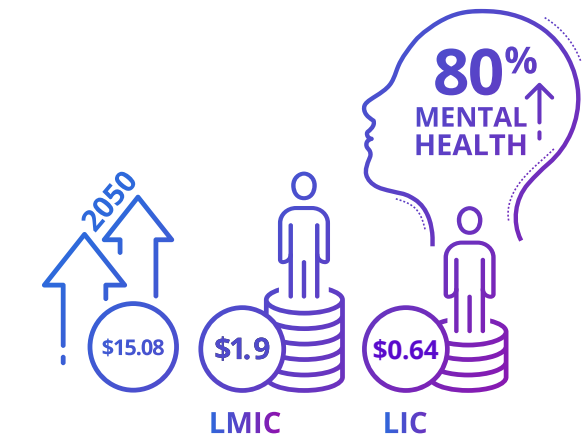
Achieving 50% service coverage by 2030

Achieving the much more ambitious target of achieving 50% service coverage by 2030 for the five mental health conditions (anxiety, depression, epilepsy, bipolar disorder and psychosis) – rather than a 50% increase in existing coverage – would require global mental health expenditure to increase by an annual rate of 20% to US\$85.5bn by 2030 compared to the baseline figure of US\$73.6bn in 2022. For low- and lower-middle-income countries, this means committing to per capita expenditure of US\$0.38 and US\$1.17 respectively by 2030. This is a tiny fraction of the existing levels of per capita health expenditure reported by the World Bank, ^{xvii} which stands at US\$33.8 for low-income countries and US\$95.25 for lower-middle-income countries as of 2019.



Achieving 80% service coverage by 2030 or 2050

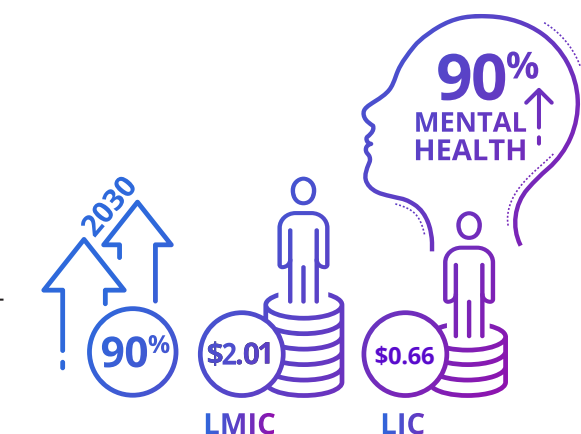
Reaching service coverage of 80% for the five mental health conditions would require a commitment of approximately US\$6.4bn annually by 2030 in low- and lower-middle-income countries, but it's an investment that offers exponential returns.



If the target date for achieving 80% service coverage for the five mental health conditions were extended to 2050, it would require per capita global expenditure of US\$15.08. The contributions of low- and lower middle-income countries amount to a comparatively smaller sum of US\$0.64 and US\$1.90 per capita, respectively.

Achieving universal coverage

It is financially viable to achieve universal coverage or close to it – 90% coverage or more – for the five mental health conditions by 2050. It would require a minimum global increase in mental health financing of \$0.26 per capita per year, and of just US\$0.02 for low-income countries and US\$0.06 for lower-middle-income countries.



Reaching universal coverage by 2030 would require an increase in the ratio of global mental health expenditure of 1.9 compared to 2022, and a rise in annual per capita spending to US\$0.66 and US\$2.01 for low-income and lower-middle-income countries respectively. Regardless of how long it takes to get there, achieving universal mental health service coverage and focusing expenditure on PHC and community-based care should remain a priority.

Research limitations

All modelling of this type has limitations. A significant limitation here is not accounting for the diseconomies of scale that might occur when seeking to achieve very high coverage rates. In other words, as the coverage of mental health services increases, the need to account for patient preferences about accessing mental health care combined with the additional resources needed for identifying cases and promoting treatment-seeking could increase the cost of scaling up mental health treatment coverage.

The forecasts given in this report are hypothetical. Therefore the data should be seen as a guide to what could be achieved and how much that would cost. The purpose is to show that nothing is impossible: we can and should strive to achieve good mental health for all.

Please contact info@unitedgmh.org for the methodology.

POTENTIAL RETURN ON INVESTMENT

The data suggests that there are significant returns to be made from closing the mental health coverage gap as part of UHC, both financially and in terms of the benefit to individual human lives.

The return on investment

There is a clear link between mental health and economic performance. Investment in mental health focused on primary health care and non-specialist healthcare settings leads to large productivity gains.^{xix} A WHO report projects that spending US\$1 to reduce the mental health service coverage gap can yield a return of US\$5. The projected returns are even higher for specific interventions, such as school-based interventions that target anxiety, depression and suicide. The State of the World's Children report found that every US\$1 spent in this way over 80 years would yield US\$21.5. **For low-income and lower-middle-income countries that return was estimated to be a massive US\$88.7 and US\$67.6 respectively.**

As we recover from the pandemic, we must continue to build up mental health services.

Everyone deserves access to support.

The health impacts ('return on the individual')

The potential returns for human health are tremendous. Our research used the WHO's OHT to estimate the health benefits of steadily increasing public mental health investment to recommended levels by 2030 or by 2050 for the five mental health conditions. We found that the outcomes of such investment between now and 2030 could be dramatic: 23.9 million healthy life years gained, 51.5 million prevalent cases avoided, and 478,000 deaths averted for the five mental health conditions.

When modelling the financing of an increase to 90% coverage rates for the five mental health conditions between now and 2050 the predicted health outcomes are even better. We estimated over 500 million healthy life years would be gained, just under 1.5 billion cases of the five common mental health conditions prevented, and more than 6 million deaths averted.

We'll explore the full results, including those disaggregated by country income group, in the next briefing in this series.

The cost of inaction

The economic cost of failing to close the global mental health services gap has been calculated at **a staggering US\$387.2 billion a year**,^{xx} and could total **US\$6 trillion between now and 2030**.^{xxi} Mental health conditions, including depression and anxiety, cost the global economy **US\$340.2bn every year**, and the loss of life from suicide results in a **US\$47bn economic loss**.

According to UNICEF's 2021 State of the World's Children report, a child between the age of 11 and 19 dies by suicide every 11 minutes. It cites evidence to suggest a direct correlation between an increase in suicide rates and a lack of access to mental health services,^{xxii} which in part stems from inadequate financing and/or lack of appropriately targeted financing.

This all underlines the urgent need for increased financing for mental health as part of UHC.

WHY FINANCE MENTAL HEALTH AS PART OF UHC?

The Lancet Commission on Global Mental Health and Sustainable Development recommended that mental health be integrated into UHC.^{xxiii}

The multiple comorbidities of mental and physical health conditions (covering both communicable diseases such as TB and HIV, and noncommunicable diseases such as diabetes and cardiovascular disease) mean mental health is a core component of delivering holistic,

person-centred and cost-effective care, and making UHC a success. When mental health services are integrated into physical health programmes, the combined treatment contributes to better overall health outcomes.^{xxiv}

So, financing for mental health shouldn't be viewed in isolation from physical health spending – especially as evidence suggests the overall cost of care can be reduced by integrating mental health into UHC.^{xxv}

The timing is also right to accelerate mental health financing through UHC. In June 2019, there was the first ever G20 Finance and Health Ministers joint session aimed at galvanising G20 countries to increase financing for UHC in developing countries. The UN high-level meeting on UHC in 2019 was the first such meeting to include mental health as part of UHC in its negotiated political declaration. It talked about achieving efficient health financing policies, quality investment in health services and optimal budgetary allocations all geared towards achieving UHC by 2030.^{xxvi}

With the next high-level meeting on UHC in 2023 and UHC forming such a crucial part of pandemic response and recovery discussions, now is the time to ask for greater financing for mental health services within the context of UHC.

FINANCING MENTAL HEALTH AS PART OF UHC

Integration into UHC financing schemes

Mental health services can be most efficiently and effectively financed from within UHC and other financial protection schemes. As countries move towards achieving UHC by 2030, through financing mechanisms such as national social health insurance schemes, it is crucial that mental health interventions and services are included. Making essential mental health services free to all at the point of use, including in PHC and community-based care settings, is a key component of meeting international commitments to achieving universal access to mental health support.

Budgets, cross-government, national development plans

The levels of investment required to finance mental health need to be evaluated through investment cases, such as those being conducted by the WHO Special Initiative for Mental Health.^{xxvii} Investment should be integrated within physical health programme budgets, such as for HIV, as well as dedicated mental health programme budgets. This will help create effective and universal mental health systems within public health systems. As many countries move toward programme-based budgets for health, there are opportunities to incorporate mental

health resource needs within those programme budgets. This will improve the integration of mental health into physical health services, making mental health finance more sustainable and providing greater equality of access to care.

The financing of good mental health services is not the sole responsibility of the health sector. Many other areas of government can play a role in delivering a holistic approach to prevention, promotion and treatment in mental health, and should share the cost of doing so. It is important to highlight that the costs of preventing poor mental health up front are a fraction of the costs paid by society throughout the life course. It is also vital to note that investing in vulnerable groups, such as children and caregivers, is an essential element of preventing and treating mental health problems and of overcoming the massive treatment gap, particularly at primary and community-care level. A whole-of-government approach is easier to implement and good mental health policies easier to finance when spending is seen as a proportion of a government's overall budget, rather than solely as part of its health budget.^{xxviii} In Liberia, for example, it would require over 11% of the national health budget to fund the full implementation of its widely praised national mental health policy, but only 1.8% of total government spending.^{xxix}

The funding of any health system requires difficult decisions about which services to prioritise. National budgets change from year to year as different priorities emerge. Medium-term budgetary frameworks (MTBF), which typically run for a three-year period, can help provide stability, including for mental health budgeting and planning. MTBFs can, in turn, be informed by longer term (usually five-year) national development plans (NDPs) and set a course for national spending. Therefore, it is important to not only promote mental health during annual budget consultations, but also to integrate mental health into NDPs to improve stable and sustainable finance for mental health. There is a key opportunity to do so as countries prepare their Voluntary National Review reports ahead of a special summit in 2023, detailing their progress and plans towards achieving the SDGs, including on mental health.

The role of external finance

There are many countries where the gap between current and adequate levels of mental health finance is large. In these cases, finance from external sources such as official development assistance (ODA) can strengthen mental health systems or catalyse domestic resource mobilisation. However, in 2019, only US\$160m of development assistance for mental health (DAMH) was available to spend,^{xxx} against the US\$1.9bn required annually.

In the short term at least, the quickest, and most low-cost way to increase mental health finance in low- and middle-income countries appears to be by integrating DAMH into existing emergency responses, development programmes and established financing mechanisms, such as the Global Fund to fight AIDS, TB, and Malaria. Not only is this a faster route to dramatically increasing mental health finance, but it also helps integrate mental health into physical health systems and other social programmes, such as education.

Philanthropic donors, who contributed one third of total DAMH (US\$364.1million) between 2000 and 2015,^{xxxi} also have a critical role to play in financing mental health services. And international financing packages can be catalytic – providing incentives for increases in sustainable domestic finance for mental health, as the Global Financing Facility has done for overall health budgets.

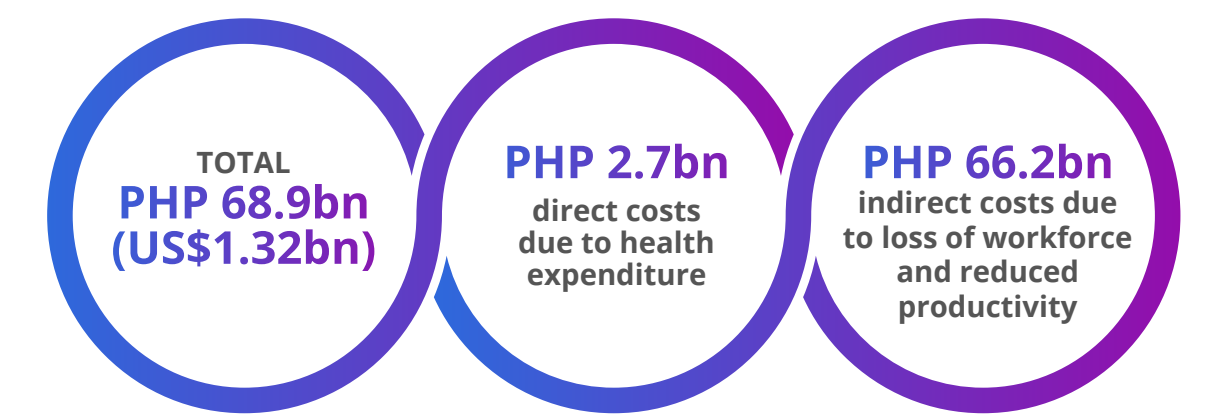
CASE STUDIES ON THE OUTCOMES OF MENTAL HEALTH FINANCING

The case for investment as worded by a service user from Pakistan

Zeeshan Ahmad from Pakistan had difficulty accessing treatment for depression. In the video below he makes the case for greater financing for mental health to address the lack of services – and the stigma surrounding mental ill health – that made getting treatment difficult. And he calls for doctors to be equipped to identify mental health conditions, as well as physical health problems, given the interconnections between the two.



BURDEN OF MENTAL HEALTH CONDITIONS



The case for investment in mental health services in the Philippines^{xxxiii}

The following table outlines the case for investment to close the mental health treatment gap for certain clinical packages in the Philippines, a WHO Special Initiative Country. ^{xxxii} It recommends an investment framework over 10 years and projects the return on investment.

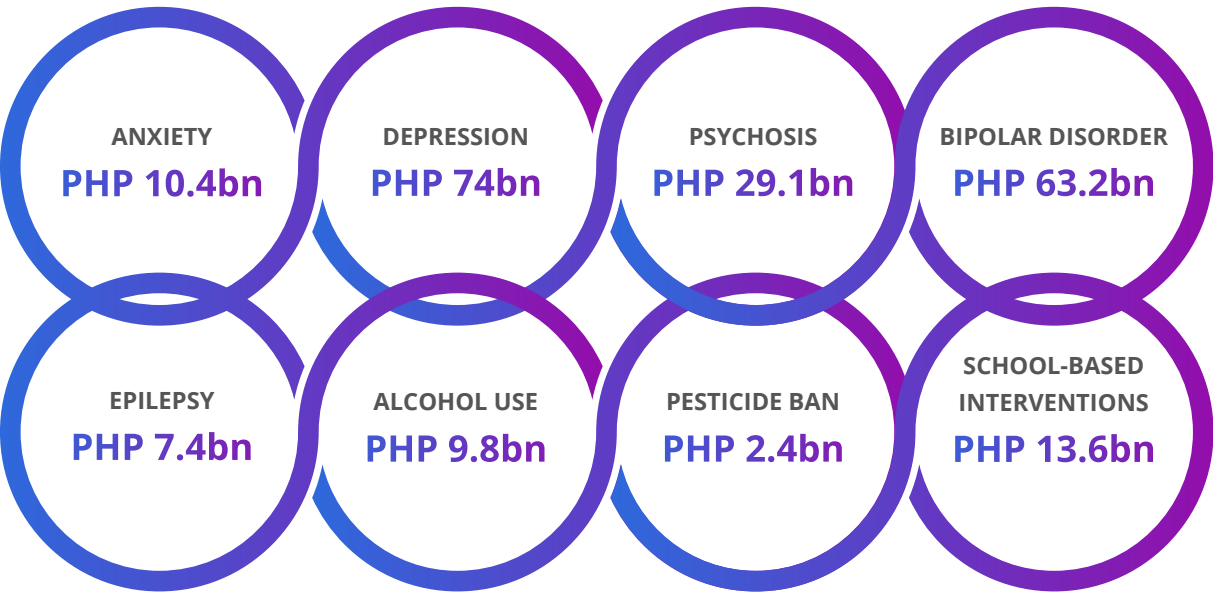
The treatment gap (using basic coverage figures)

Type	Anxiety	Depression	Psychosis	Epilepsy	Bipolar disorders	Alcohol use	Pesticides ban	School based
Current coverage	5%	5%	20%	40%	20%	5%	70%	5%
Target coverage (by 2040)	30%	30%	60%	90%	60%	30%	100%	100%

Recommended investment over 10 years



Investment breakdown



The return on investment

Total return on investment:	PHP 217bn
Healthy life years gained:	724,195
Prevalent cases averted:	1,748,020
Deaths avoided:	5,344
Productivity gains:	PHP 216bn

The table above outlines both the health and economic rationale for investing in evidence-based, WHO-recommended interventions that are in line with community-based, integrated approaches. The Philippines investment case shows that increased financing for mental health not only prevents mental health cases but can provide a decent return.

CONCLUSION

The data shows that while there is a gap in coverage for basic mental health services, the financing required to bridge that gap is achievable for national governments. It also demonstrates that increased financing for mental health offers a wealth of potential health and economic benefits for individuals and across society. Governments, supported by domestic and international donors, must now commit adequate financing, especially directed to primary health care and community-based care, and to particularly vulnerable groups such as children and caregivers, to reap those rewards.

Annex 1 – Required financing to meet coverage targets for anxiety, bipolar disorder, depression, epilepsy, and psychosis by either 2030 or 2050.

Mental health expenditure - Target coverage of 50% by the year 2030 and 2050					
Parameter	Low income	Lower-middle income	Upper-middle income	High income	All countries
Population in 2022	665,149,040	3,330,652,550	2,522,452,390	1,214,930,230	7,733,184,210
Mental health government expenditure in 2022 - per capita (USD)	\$0.08	\$0.37	\$3.29	\$52.73	\$9.52
Mental health government expenditure in 2022 - total (USD, millions)	\$53.2	\$1,232	\$8,299	\$64,063	\$73,648
Population in 2030	808,751,917	3,691,396,245	2,606,099,619	1,244,962,871	8,351,210,649
Ratio of mental health expenditure for 2030 versus 2022	4.8	3.2	2.2	1.1	1.2
Mental health government expenditure in 2030 - per capita (USD)	\$0.38	\$1.17	\$7.15	\$56.08	\$11.06
Mental health government expenditure in 2030 - total (USD, millions)	\$254.8	\$3,897	\$18,036	\$68,136	\$85,498
Population in 2050	1,227,982,690	4,459,526,835	2,645,231,266	1,277,733,305	9,610,474,086
Ratio of mental health expenditure for 2050 versus 2022	5.2	3.3	2.2	1.1	1.1
Mental health government expenditure in 2050 - per capita (USD)	\$0.42	\$1.24	\$7.21	\$59.02	\$10.51
Mental health government expenditure in 2050 - total (USD, millions)	\$277.0	\$4,120	\$18,194	\$71,701	\$81,286
Mental health expenditure - Target coverage of 80% by the year 2030 and 2050					
Population in 2022	665,149,040	3,330,652,550	2,522,452,390	1,214,930,230	7,733,184,210
Mental health government expenditure in 2022 - per capita (USD)	\$0.08	\$0.37	\$3.29	\$52.73	\$9.52
Mental health government expenditure in 2022 - total (USD, millions)	\$53.2	\$1,232	\$8,299	\$64,063	\$73,648
Population in 2030	808,751,917	3,691,396,245	2,606,099,619	1,244,962,871	8,351,210,649
Ratio of mental health expenditure for 2030 versus 2022	7.4	4.9	3.4	1.5	1.7
Mental health government expenditure in 2030 - per capita (USD)	\$0.59	\$1.81	\$11.09	\$78.45	\$15.83
Mental health government expenditure in 2030 - total (USD, millions)	\$394.2	\$6,029	\$27,963	\$95,317	\$122,434
Population in 2050	1,227,982,690	4,459,526,835	2,645,231,266	1,277,733,305	9,610,474,086
Ratio of mental health expenditure for 2050 versus 2022	8.0	5.1	3.4	1.6	1.6
Mental health government expenditure in 2050 - per capita (USD)	\$0.64	\$1.90	\$11.12	\$82.80	\$15.08
Mental health government expenditure in 2050 - total (USD, millions)	\$426.1	\$6,338	\$28,049	\$100,596	\$116,611

Mental health expenditure - Target coverage of 90% by the year 2030 and 2050					
Population in 2022	665,149,040	3,330,652,550	2,522,452,390	1,214,930,230	7,733,184,210
Mental health government expenditure in 2022 - per capita (USD)	\$0.08	\$0.37	\$3.29	\$52.73	\$9.52
Mental health government expenditure in 2022 - total (USD, millions)	\$53.2	\$1,232	\$8,299	\$64,063	\$73,648
Population in 2030	808,751,917	3,691,396,245	2,606,099,619	1,244,962,871	8,351,210,649
Ratio of mental health expenditure for 2030 versus 2022	8.2	5.4	3.8	1.7	1.9
Mental health government expenditure in 2030 - per capita (USD)	\$0.66	\$2.01	\$12.35	\$87.39	\$17.63
Mental health government expenditure in 2030 - total (USD, millions)	\$438.8	\$6,710	\$31,149	\$106,174	\$136,370
Population in 2050	1,227,982,690	4,459,526,835	2,645,231,266	1,277,733,305	9,610,474,086
Ratio of mental health expenditure for 2050 versus 2022	8.9	5.7	3.8	1.8	1.8
Mental health government expenditure in 2050 - per capita (USD)	\$0.71	\$2.11	\$12.37	\$92.32	\$16.80
Mental health government expenditure in 2050 - total (USD, millions)	\$473.4	\$7,042	\$31,191	\$112,157	\$129,916
Mental health expenditure - Target coverage involving 50% increase by the year 2030 and 2050 (Comprehensive Mental Health Action Plan 2013-2030 Target)					
Population in 2022	665,149,040	3,330,652,550	2,522,452,390	1,214,930,230	7,733,184,210
Mental health government expenditure in 2022 - per capita (USD)	\$0.08	\$0.37	\$3.29	\$52.73	\$9.52
Mental health government expenditure in 2022 - total (USD, millions)	\$53.2	\$1,232	\$8,299	\$64,063	\$73,648
Population in 2030	808,751,917	3,691,396,245	2,606,099,619	1,244,962,871	8,351,210,649
Ratio of mental health expenditure for 2030 versus 2022	1.5	1.5	1.5	1.3	1.2
Mental health government expenditure in 2030 - per capita (USD)	\$0.12	\$0.57	\$4.98	\$67.72	\$11.88
Mental health government expenditure in 2030 - total (USD, millions)	\$82.3	\$1,909	\$12,558	\$82,271	\$91,844
Population in 2050	1,227,982,690	4,459,526,835	2,645,231,266	1,277,733,305	9,610,474,086
Ratio of mental health expenditure for 2050 versus 2022	1.7	1.6	1.5	1.4	1.2
Mental health government expenditure in 2050 - per capita (USD)	\$0.14	\$0.61	\$5.03	\$71.31	\$11.20
Mental health government expenditure in 2050 - total (USD, millions)	\$90.1	\$2,025	\$12,680	\$86,641	\$86,626

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An abstract network diagram in the bottom left corner, featuring a complex web of interconnected nodes and lines. The nodes are represented by circles of varying sizes, some solid and some outlined, connected by thin lines. The overall structure is dense and organic, resembling a molecular or neural network.

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