Disparity between burden and budget for mental health

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The study by Daniel Vigo and colleagues[1] provides new secondary analysis to strengthen the case for increased investments in mental health in the Americas. These data are very timely coming soon after the publication of the *Lancet* Commission for Global Mental Health and Sustainable Development,[2] which recommended reframing mental health and making larger investments nationally and internationally.

WHO has presented data through its Atlas publications on the budget devoted to mental health since 2001, the latest version being Mental Health Atlas 2017;[3] but the evidence presented by Vigo and colleagues goes farther than previous attempts and is especially interesting since it is for the Americas region—a region with wide variation in income levels between countries and with a rich history of reforms in the mental health system.[4]

The method for calculating the burden of mental disorders, neurological disorders, and substance use disorders, self-harm, and suicide, has been used previously[5] and does more justice to the burden estimates than the original estimates of Institute for Health Metrics and Evaluation.[6] The method used to calculate the allocative efficiency of use of health budget devoted to mental health is new and innovative. Although use of this method is a step forward in deriving a measure of efficiency, the assumptions made are too tenuous and are not generalisable. For example, it is assumed that services for acute schizophrenia cannot be provided in community-based services. The WHO's Atlas project actually includes psychiatric wards in general hospitals as community-based facilities,[3] and acute schizophrenia (along with other acute psychoses) can be, should be, and are treated in these facilities.

Interestingly, Vigo and colleagues' study presents country-level data,[1] allowing countries to compare themselves with others and to learn from each other, which can be a good incentive for change. Based on the data presented, Vigo and colleagues conclude that poorer countries spend a lower proportion of their health budget on mental health and they also allocate these scarce budgets less efficiently, spending a large proportion on psychiatric hospitals. Although these findings are important and need to be disseminated and used for policy action, they could be misinterpreted and misused. An explanation should not become an excuse. These countries should not wait for an improvement in economic wealth before increasing the proportion of their health budget to mental health and using the allocation more efficiently. Evidence suggests that interventions for mental health are cost-effective[7] and the return on investment for at least some conditions is attractive.[8] All countries must act now to increase investments for mental health to establish community-based service systems, which they have committed to do by endorsing the WHO Mental Health Action Plan 2013–20. The unacceptably high treatment gap for eminently treated conditions, such as major depressive disorders, of 78% in high-income countries, and as high as 96% in low-income and lower-middle-income countries,[9] can be decreased only with a substantially higher investment in community-based mental health services.

Eventually, improved development and use of methods will be needed to more accurately account for the estimation of health budget allocated to community-based mental health services. This task is likely to become more urgent as countries increasingly act on incorporating mental health care within universal health coverage and integrate it within primary health care, which will make the existing methods for estimating the budgets for mental health quite obsolete and unworkable. These newer and better methods can then be used by the independent accountability mechanism that the *Lancet* Commission[2] recently recommended.

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