

Fiscal realities and future directions: insights and innovations from South Africa's Mental Health Investment Case

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Aim

Mental health is increasingly recognised as a key component of national development and health equity, yet investment remains insufficient. This paper presents the South African Mental Health Investment Case, which aims to inform policy and financing decisions, particularly within the National Health Insurance framework, by estimating the costs, implementation requirements, and potential returns of scaling-up mental health services.

Method

The Mental Health Investment Case was developed in two phases. Phase 1 involved a national costing analysis to estimate current spending and identify inefficiencies and gaps. Phase 2 employed a structured Delphi process and stakeholder consultations to prioritise a package of clinical and programmatic interventions, which were then costed using a bottom-up modelling approach. Projected returns on investment were calculated based on productivity gains and avoided illness and mortality.

Results

Modelling indicates that scaling up cost-effective interventions, particularly for common mental disorders, can significantly increase coverage, yield high returns, and reduce treatment costs over time. Stakeholders highlighted implementation barriers, including fragmented governance, lack of dedicated financing, and weak intersectoral collaboration. Recommendations include dedicated provincial mental health directorates, formalised multi-sectoral co-ordination platforms, strengthened monitoring and evaluation systems, and a phased implementation plan aligned with fiscal realities.

Conclusion

The Mental Health Investment Case provides an evidence-informed roadmap for strengthening mental health systems in South Africa. It expands the investment case by incorporating efficiency, equity and rights-based arguments. The findings support the development of tailored implementation guidelines, prioritised benefit entitlements under NHI, and dedicated budgeting mechanisms such as conditional grants. Sustained advocacy, inter-departmental collaboration, and robust data systems will be essential to ensure delivery of equitable and effective mental health care.

Introduction

Mental health is increasingly occupying the global health and development policy discourse. Most (80%) of the global burden of mental health conditions affect people

living in low- and middle-income countries (LMICs).¹ Mounting evidence shows that improved population mental health and well-being is a prerequisite for human and societal benefit.²⁻⁷ Yet, insufficient investments maintain a status quo of limited or absent mental health care. Globally, public expenditure on mental health is es-

estimated at 2.1% of government health expenditure, and is lowest among LMICs, ranging between 0.5% and 1.9%.⁸ It bears mentioning that data on this indicator were limited, with only one-third of World Health Organization (WHO) Member States reporting on mental health expenditure. Alarming, this reality imposes immense costs on individuals, households and governments alike. Between 2011 and 2030, global economic losses attributed to mental health problems will amount to US\$16 trillion,⁹ with common mental conditions alone costing the global economy US\$ 1 trillion annually.¹⁰

To inform national-level investment decisions, the WHO and the United Nations Development Programme have guided and supported the development of national mental health investment cases (MHICs) as a fundamental mechanism for improving mental health financing. These have been undertaken in a number of LMIC contexts in recent years, including Ghana, Kenya, Uganda, Zimbabwe, Bangladesh, and Nepal.¹¹

MHICs describe the costs of a specified package of mental health interventions and the estimated health, social and economic returns on investment. The need for an MHIC was particularly pertinent in South Africa in 2016, when the nation witnessed the catastrophic scale of devastation, loss of life, and indignity inflicted on mental healthcare users (MHCUs) during the Life Esidimeni tragedy. This highlighted the urgent need for substantial and fundamental changes in our nation's response to the mental health and well-being of its citizens, and ignited a deliberative process to make the case for expanded mental health investments.

Achieving universal health coverage (UHC) in South Africa is particularly challenging due to the country's complex and deeply unequal healthcare system, with well-acknowledged inequities between the country's public and private sectors. Expenditure per person is over ZAR 20 000 in the private sector, in stark contrast to that in the public sector which is estimated at approximately ZAR 5 000 per person per year.¹² Furthermore, the Human Resource Strategic Plan notes that in comparison to a density of 0.38 psychiatrists in the public sector, the private sector reports the availability of 4.98 psychiatrists per 10 000 population.¹³ To address these disparities, National Health Insurance (NHI) was introduced in 2011¹⁴ and enacted in 2024. However, key details on coverage, benefits, and entitlements remain unclear. Concerns persist about the affordability and sustainability of NHI amid stagnant health budgets¹⁵ and growing economic pressure.¹⁶ Without explicit inclusion of mental health priorities in NHI implementation, mental health risks continued neglect.^{17,18}

The South African MHIC has been developed over several years of dialogue and collaboration to strengthen the country's capacity to generate and use economic evidence to scale up and improve mental health services.¹⁹ This work aimed to address the policy and implementation failures of the lapsed 2013–2020 National Mental Health Policy Framework and Strategic Plan (NMHPFSP), inform the new policy, provide a rational approach to

new investments for mental health care, and support the inclusion of key mental health interventions in the NHI Service Benefits Framework.

This paper aims to describe the innovations of the South African MHIC, presenting the economic case for investments in mental health, and critically examining whether a reformed approach to MHICs — one that aligns more closely with the needs of the ministries of Health and Finance and is underpinned by innovative methods — is warranted and can achieve its intended purpose. It explores the rationale for prioritising mental health care within South Africa's overall healthcare plans, and the critical role of robust partnerships in achieving mental health equity through comprehensive and inclusive planning. The paper also explores perspectives from the Treasury Department on South Africa's fiscal climate and its capacity to deliver on the recommendations emerging from the MHIC.

Method

The MHIC was undertaken in two key phases, each specifically designed to build the case for expanded investment in mental health services. The first formative phase, with findings already published, focused on evaluating the health system costs of current mental health service provision.²⁰ This was intended to understand current investments in mental health services and the distribution of resources across the country and levels of the health system. Expenditure on mental health in 2023 was estimated at ZAR 11.5 billion (inflated from 2016/17 estimates), reflecting 5% of the health budget and falling within the lower end of globally recommended norms of 5%–10%⁷ and already more than twice the current global average. Findings from this phase highlighted significant disparities in mental health expenditure and resources across provinces, inefficient investments in hospital-centric services (ZAR 5.6 billion spent at the specialised hospital level), long lengths of stay, high re-admission rates, and a substantial treatment gap (over 90%). With this baseline information at hand, the second phase of work was initiated to provide a rational process for planning both mental health and general system reforms.

The second phase focused on defining a priority package of clinical and programmatic mental health interventions for scale-up, estimating their cost and expected return on investment (ROI) over a 15-year period. This included costs for community and hospital-based infrastructure, human resource requirements, programmatic enablers, and support systems necessary for implementation.

Intervention and enabler selection

The selection of clinical, psychosocial, rehabilitative, preventive, programmatic, and infrastructural interventions for Phase 2 was informed by several processes. First, a review of national and global clinical guidelines was undertaken, including the WHO Mental Health Gap Action

Programme (mhGAP)²¹ and the Disease Control Priorities Volume 3 (DCP 3) on mental neurological and substance-use disorders (MNS) conditions.²² This was followed by a structured three-phase Delphi process involving multidisciplinary experts to score and prioritise interventions based on criteria²³ including relevance, effectiveness, acceptability, and feasibility.

This contributed to broader considerations beyond cost-effectiveness in the overall recommendations, and aimed to identify areas of discordance and synergies between global recommendations and those of local stakeholders with unique experience and involvement in the South African mental health delivery landscape.

The Delphi study, conducted with 66, 47, and 21 participants across three rounds, covered 12 broad focal areas identified by the National Department of Health's Mental Health Think Tank. These were: community-based care for severe mental disorders; Primary Health Care (PHC) integration for depression/anxiety; maternal and child mental health; adolescent mental health; emergency substance-use support; in-patient infrastructure and more specifically dedicated mental health units within hospitals; monitoring and evaluation; adherence and relapse prevention; district-level planning and health management; intersectoral co-ordination; mental health promotion/prevention; and forensic mental health. The final output was a list of 48 prioritised interventions across 10 thematic areas.

Lastly, stakeholder consultations were conducted with six Provincial Departments of Health through participatory workshops and semi-structured interviews with 42 key informants across health and non-health sectors using a purposive maximum variation sampling approach.²⁴ These engagements aimed to gather insights on provincial constraints, priorities and opportunities for mental health service delivery. NVivo (2020 Release) software was used to store data and undertake a framework analysis, which is a structured qualitative data analysis method that enables inductive and deductive analysis.²⁵ Technical consultations were also held with key national and academic experts to validate recommendations.

Modelling and costing approach

Modelling was conducted using the WHO Inter-UN One-Health Tool²⁶ and a linked Excel-based model to estimate population coverage, resource needs, costs, and health outcomes over a 15-year period (2020–2035) for the South African public sector. Service delivery scale-up was based on guideline-informed coverage targets, taking into account current coverage estimates based on the costing study (under 10%), realistic scale-up scenarios (target coverage rates not exceeding 50%), and WHO-recommended shifts from institutional to community-based care.

This investment case adopted a provider perspective to estimate the financial cost of scaling-up mental health services, aligning with WHO mhGAP recommendations and adapted to South Africa's Adult Primary Care (APC) guidelines. Costing was conducted in 2020 ZAR and USD

real terms, with future costs discounted at a rate of 3% to obtain net present values. Clinical interventions included: care for anxiety, depression (including perinatal depression), psychosis, bipolar disorder, epilepsy, developmental disorders, dementia, and substance-use conditions. Non-clinical components covered: workforce development (e.g. training, supervision, District Mental Health Specialist Teams (DMHST)), governance structures, planned patient transport, and inter-facility referral systems. Infrastructure costs were estimated for in-patient psychiatric units, community residential and day-care services, forensic facilities, and substance-use rehabilitation centres. Preventive and promotional interventions included: school-based social and emotional learning (SEL) programmes, brief alcohol-use interventions, and national mental health awareness campaigns. Sector-specific costs were aligned with departmental mandates.

Both direct medical and non-medical costs were included. These comprised clinical care (medication, human resource time), programmatic enablers (training, governance structures, supervision), infrastructure (new psychiatric units, community-based day, and residential care), and population-level health promotion efforts (e.g. radio campaigns, school-based SEL programmes). Capital investments were disaggregated from recurrent costs, and cost estimates were presented across Medium-term Expenditure Framework (MTEF) periods. At the PHC level, total treatment costs were estimated using an ingredients-based approach, which accounted for the categories of resource use outlined above. Costs were calculated by multiplying the quantity of each resource required per patient by its unit cost, adjusted for patient volume and the annual PHC coverage rate. For hospital-based care, annual intervention costs were derived by multiplying the number of out-patient visits and in-patient days per patient by the estimated cost per patient day equivalent, factoring in relevant coverage rates.

Given that this analysis drew on local costs for medication and supplies, as well as human resources for health, a sensitivity analysis around costs was not warranted. Although indirect costs such as productivity losses were not included in the financial costing, they were accounted for in the estimation of ROI through monetisation of health impacts.

Return on investment and cost of inaction

Health outcomes were measured as healthy life years (HLYs) gained, equivalent to disability-adjusted life years (DALYs) averted using Global Burden of Disease disability weights. Monetised benefits were estimated following guidance from the Lancet Commission on Investing in Health, with each HLY valued at 1.6 times GDP per capita (1.1 for productivity gains and 0.5 for intrinsic well-being).^{27,28} Productivity was defined broadly to include formal employment, informal labour, caregiving, and household production. Direct labour force outcomes were estimated where data allowed.

Health outcomes were estimated using effect sizes from high-quality meta-analyses and clinical trials²⁹⁻³² adjusted for real-world adherence and service delivery realities. These effects were converted into HLYs using Global Burden of Disease (GBD) disability weights. ROI was calculated as the ratio of total monetised benefits to the investment cost. To estimate the cost of inaction, the model projected HLYs lost under a no-scale-up scenario and applied the same valuation method. The model incorporated both morbidity-related losses (from reduced functioning and chronic disability) and premature mortality. Further details on the costing and ROI methodology and treatment assumptions can be found in the full investment case report.¹⁹

Results

Priorities for South Africa: Delphi findings

The Delphi study identified several priority interventions for mental health with substantial consensus, reflecting the wide scope of considerations adopted in the MHIC. Key areas included: substance-use treatment; child and adolescent mental health; integrated primary health care for depression and anxiety, as well as the integration of mental health into maternal and child health programmes; treatment for severe mental illness; mental health prevention and promotion including community-based residential and out-patient options; rehabilitation; and occupational therapy. Additionally, forensic, old-age and workplace mental health were identified as priorities. Delphi participants also voted on 18 key indicators for inclusion in the country's health information system to assess the current burden of MNS conditions, treatment coverage, and patient care pathways to adequately monitor mental health service delivery.

Provincial stakeholder perspectives and recommendations

Stakeholder engagement through provincial workshops and interviews revealed several systemic implementation challenges and priorities. Participants validated MHIC cost findings and provided deeper insight into the feasibility of reforms under current provincial and inter-sectoral constraints.

Governance, policy translation, and system leadership

Stakeholders emphasised the gap between national mental health policy and sub-national implementation capacity. Many provincial officials expressed concern about the unrealistic targets of the 2013–2020 NMHPFSP, inadequate budgeting, and limited alignment with provincial mandates and structures:

That policy has to be reviewed... some of those targets are totally idealistic. Things have changed. The

economy has changed. (Western Cape workshop participant).

And:

Besides the financial [commitment], I would say prioritise policy, which we do... but also the implementation thereof. (Stakeholder interview, NGO participant).

Turnover in political leadership further undermined continuity in mental health prioritisation:

This is the third MEC I've had to convince... every time one leaves, we start again. (Stakeholder interview, NDoH).

Intersectoral collaboration and community-based services

While stakeholders strongly endorsed intersectoral collaboration in principle, they reported fragmented co-ordination, unclear mandates, and inconsistent participation in provincial mental health fora. Participation of decision-makers was often limited, and many fora lacked formal terms of reference or mechanisms for accountability. For example:

There are sectors coming to the table, but not as they should... there's nothing mandating them together. (Stakeholder interview, Human Settlements).

Traditional healers, civil society and community-based organisations were frequently excluded, despite their importance in culturally responsive and locally embedded service delivery:

Psychology is a Western principle... it's imperative that traditional healers are involved. That's looking at it from an African perspective. (North West workshop participant).

There was also strong support for expanding community-based mental health services, with recommendations to streamline NGO compliance processes and integrate care with social development and municipal services.

Child, adolescent, and forensic mental health

Specific concerns were raised about limited access to services for children and adolescents. Stakeholders proposed strengthening school health programmes through routine mental health promotion, mental health screening, trained personnel, and investment in specialised educational services. Substance use disorders and forensic mental health were also identified as major service gaps.

Financial feasibility and accountability

Across all provinces, the absence of ring-fenced mental health budgets and lack of financial transparency were seen as major barriers. Many noted that conditional grants were either underspent or repurposed, with lim-

ited visibility over where and how mental health funding was allocated:

When you ask for something, they say: 'There's no money.' That's the reflex action. The idea of no money is nonsense! (District health representative from the Northern Cape).

Similarly, from a Northern Cape workshop participant:

Our provinces are gladly giving the grants back...they want to use it (sic) for other things.

The fragmentation of funding across departments further limits efficiency:

Departments owe each other money. There is no interlinked budget. Everyone has their own, and that's it. (Stakeholder interview, Human Settlements).

Human resources and capacity -building

There was unanimous concern about shortages and high turnover of mental health professionals. Stakeholders advocated for expanding targeted training programmes, investing in task-shifting and supervision models, strategic recruitment and retention incentives, and strengthened supervision and support structures for PHC providers.

Monitoring and evaluation

There was strong consensus that monitoring systems are insufficiently developed. Current health information systems do not track referral pathways, diagnoses, or service quality. Stakeholders expressed concern that Annual Performance Plan (APP) indicators incentivise discharges over recovery, undermining continuity of care. For example:

The indicators are not about the person you're treating. It's about the tick box. (Stakeholder interview, NDoH).

And:

Patients are being discharged too early to meet the 72-hour target. (Northern Cape workshop participant).

Stakeholders further recommended developing culturally appropriate evaluation tools and involving communities in participatory monitoring of service quality and responsiveness.

Resource needs

Based on the costing and modelling exercise, the scale-up of mental health services over the 15-year period is expected to result in a 5.3-fold increase in the number of persons in need who receive care, from an estimated 731 872 cases reached to 3 885 596 cases. The investment needed by the NDoH, however, is substantial, estimated at ZAR 327.3 billion over the full scale-up period or an annual

average of ZAR 21.8 billion. This translates to 9.7% of the current health budget and 7.6% of the projected 2035 budget. The MHIC also calls for contributions by other departments, namely the Departments of Basic Education, Social Development, and Human Settlements — all of which reflect less than 3% of their respective budgets. In order to match the most comprehensive mental health systems in the world, international recommendations are that countries should expect to allocate up to 10% of the total health budget to mental health.⁶

Importantly, implementation in the first MTEF period would not require a significant injection of additional funding. Increases in population treatment coverage over this period, in the absence of increased expenditure, could be achieved through efficiency gains as a result of service redistribution towards increased PHC provision. Over the full scale-up period, this would see the average cost of treatment decline by 38%. This would require sufficient training and support of generalist workers to screen and diagnose mental health care at the PHC level, fully staffed DMHSTs for supervision, sufficient infrastructure for upward referrals at district and regional hospitals, and the gradual development of an integrated community-based service platform to allow for discharge after acute stays with ongoing comprehensive support post-discharge — all of which has been enumerated and costed in the investment case.

These investments must be considered in the light of losses to the economy should MNS conditions remain unaddressed, which is estimated at 4% of South Africa's GDP (ZAR 161 billion annually or ZAR 2.4 trillion over the scale-up period). The combined economic value of this lost productivity greatly exceeds the estimated cost of both current mental health expenditure and those projected for service scale-up. When reflecting on the budgetary implications of the modelled package of interventions, total investments on facility-based treatment and rehabilitation interventions (including all non-capital service costs), represents an average of 0.46% of the country's current GDP, per year of scale-up or ZAR 313 per capita (2035 population). It should be noted that the 2020 GDP value used for these calculations was significantly contracted given the economic climate catalysed by the COVID-19 pandemic. Subsequent economic recovery means that the calculated cost of expenditure would be even less of the GDP.

Returns on investment

Reflecting on the potential returns on investment, it is estimated that the combined economic value of restored productivity alongside the social value of investment over the 15-year scale-up period amounts to ZAR 117.7 billion. While overall ROI does not exceed the cost inputs required for implementation, there are numerous conditions for which returns exceed the investments required for scale-up, reflected through benefit-to-cost ratios exceeding 1. These largely relate to interventions for adult anxiety, with returns on investment estimated at 1.5, and those for adult, childhood and perinatal depression esti-

mated at 4.0, 3.6, and 4.7 respectively. Additionally, the ROI estimated for epilepsy is 1.8. A number of preventive interventions also yield positive returns, including brief interventions for alcohol-use (estimated at 1.21), and universal school-based SEL programmes, with returns estimated at 1.9.

Discussion

The South African MHIC builds on global return on investment methods to present a stronger case for mental health investment by integrating economic modelling with human rights, equity, and health system feasibility considerations. Through structured stakeholder engagement and data driven modelling, it presents a compelling argument for expanded investment in mental health, grounded in the realities of the South African health system, the existing service delivery environment, the macro fiscal climate, and anticipated structural changes in health financing.

Provincial disparities, inefficient resource use, and a persistently high treatment gap (over 90%) highlight structural issues in the current provision of mental health care in South Africa. The MHIC proposes a transition towards integrated PHC-centred services supported by DMHST, improved referral pathways, and investment in infrastructure. The modelling demonstrates that such a reconfiguration could yield a 38% reduction in average treatment costs over time and expand access more than fivefold, even under fiscal constraints.

The modelling shows that certain conditions (including common mental health conditions and epilepsy) yield strong economic returns, with benefit-cost ratios exceeding 1. Other conditions, such as psychosis or intellectual disability, have lower direct returns due to their chronicity and likely caregiving burden, and the limitations of existing economic evaluation methods to capture social value and quality-of-life improvements. These disparities underscore a core tension in UHC: the need to make trade-offs between efficiency, equity, and human rights. By anchoring its recommendations in consensus-driven processes, the MHIC avoids a narrow cost-effectiveness lens and acknowledges the moral imperative to support the most vulnerable.

The 2023–2030 NMHPFSP³³ was released last year, with a broad vision calling for “comprehensive, high quality, integrated mental health promotion, prevention, care, treatment and rehabilitation for all in South Africa by 2030”. Notably, the new policy is aligned with several MHIC recommendations. It recognises the inefficiencies of current service configurations and calls for re-orientating care towards primary- and community-based services. New mandates include establishing regional in-patient units for children and adolescents, intersectoral collaboration platforms at all levels of government, audits of mental health infrastructure, and integration of mental health into Maternal and Child programmes, and school health services. The policy also introduces mechanisms to institutionalise monitoring and evaluation

through 18 national indicators (many of which were defined through the MHIC process), that are intended to track service quality, equity and financial protection.

The MHIC highlights that achieving its recommended service package, comprising both clinical and preventive interventions, requires not only technical feasibility but also political will, strong governance, and co-ordinated financing.

Fiscal feasibility and challenges for the National Treasury

With the shift in the domestic and global burden of disease progressively towards chronic diseases and mental health and the high burden of mental health conditions in South Africa,³⁴ the development of the MHIC represents a landmark in South Africa. However, the delay in tabling the MHIC as a formal budget bid and practical costed plan reflects a missed opportunity, particularly when contrasted with the more effectively funded HIV and TB investment cases.^{35–38} From the perspective of the Treasury, the investment case approach, when done well, analyses a range of potential interventions using economic evaluation and epidemiological tools to develop an optimal mix of interventions which maximises health outcomes at lowest cost, and uses these to guide an associated integrated plan and budget bid.

In this respect, the MHIC contains many strengths, but some areas could still be strengthened or further developed. Strengths included: (1) costing mental health services at baseline; (2) developing a prioritised benefit package of mental health services for South Africa based on economic evaluation and epidemiological considerations, and (3) costing the future package. Areas which could be strengthened in tabling the investment case as a budget bid include: (1) greater clarity on what the money would buy within integrated services, e.g. at PHC-level and how this could be monitored and evaluated as the plan progresses, and (2) development of a prioritised and sequenced plan and budget bid.

In the post-COVID period, slow economic and revenue growth associated with high debt payments have worsened the fiscal outlook and according to the budget speech³⁹ the 2023/24 combined provincial health spending declined by ZAR 5.2 billion compared to the previous year (2022/23). In real terms the combined 2024/25 provincial health spending was approximately ZAR 7.3 billion less than pre-COVID (2019/20) levels despite population growth of around 1 million per annum (National Treasury, email, July 30, 2025). This challenging fiscal environment makes it even more compelling for the health sector to refine its MHIC and associated sequenced plans and budget bids to be competitive as funds become available. It is also important for the sector to determine how services can best be restructured and reprioritised, within any given budget envelope, as more accessible and efficient service options might be available, even at current budget levels. Given the importance of mental health and its high disease burden, it is likely that spend-

ing on mental health will increase, and the MHIC can provide many aspects of the guide for the road ahead.

Limitations

There are several limitations to be acknowledged for the MHIC. Firstly, data constraints, both in availability and quality, posed challenges in estimating long-term costs and returns across sectors. Although multiple data sources were triangulated and expert inputs were incorporated, some assumptions (e.g. productivity gains, care pathways) are subject to uncertainty.

Secondly, forecasting fiscal and health impacts over a 15-year horizon carries inherent unpredictability, particularly in a context marked by economic volatility, shifting governance structures, and post-COVID-19 recovery. These projections should be interpreted as indicative rather than prescriptive.

Thirdly, while the Delphi study and stakeholder engagements aimed to build broad consensus, some voices — particularly those from under-resourced rural provinces, service users, and caregivers — may not have been fully represented. Ensuring equitable participation in future revisions of the MHIC will be critical for its legitimacy and responsiveness.

Finally, priority-setting in mental health inherently involves value judgments. Balancing interventions that offer high returns (e.g. for common mental conditions) with those targeting highly disabling, less prevalent disorders require normative decisions. While the MHIC explicitly integrates both efficiency and equity considerations, trade-offs remain unavoidable under fiscal constraints. Future iterations would benefit from a formalised, equity-informed prioritisation process.

Lessons learnt

The MHIC process has surfaced critical insights that are relevant to broader health reform:

- *Stakeholder engagement drives legitimacy and feasibility:* involving policymakers, implementers, service users, and experts ensured the MHIC recommendations were grounded in real-world priorities and constraints.
- *Provincial tailoring is essential:* a differentiated approach that recognises contextual disparities in infrastructure, workforce, and service capacity is necessary to make national-level recommendations actionable at the provincial and district level.
- *Fiscal realism enhances credibility:* by modelling efficiency gains and focusing on redistributive potential rather than costly expansion alone, the MHIC makes a pragmatic case for reform within the existing fiscal space.
- *Evidence must be linked to advocacy and accountability:* technical analysis alone is insufficient. Bridging the gap between economic evidence and budget allocation requires clear communication, political will, and institutional mechanisms for follow-through.

- *Cross-sector collaboration must be institutionalised:* given the social determinants of mental health and multi-sectoral service pathways, durable reform depends on formalised, co-funded collaboration across government departments.

Recommendations

The MHIC offers a technically sound and contextually relevant foundation for transforming mental health services in South Africa. Drawing on extensive stakeholder engagement, economic modelling, and policy alignment, the following practical recommendations are identified:

- *Translate the MHIC into a costed, sequenced implementation plan:* begin with high-impact, low-cost interventions, such as brief alcohol interventions, universal SEL programmes, and PHC-based treatment for depression and anxiety, while progressively expanding to more resource-intensive interventions.
- *Strengthen governance and management systems:* establish and capacitate Provincial Mental Health Directorates and DMHST to support planning, oversight, and accountability. These structures are essential to embed mental health across service levels and drive implementation.
- *Integrate mental health into existing service delivery platforms:* embed mental health services into PHC, maternal and child health, and school health programmes. Develop provincial implementation guidelines that address local needs, especially for under-served and rural populations.
- *Establish a mental health benefits advisory committee under NHI:* a dedicated committee should be created to define, update and oversee mental health benefit entitlements under NHI. This body should guide incremental inclusion of services based on evidence of impact, feasibility, and equity. There are concerns that unless South Africa's mental health priorities are clearly integrated into the policies and actions guiding NHI implementation, mental health risks being overlooked once again.¹⁸
- *Embed equity-informed priority-setting:* establish transparent decision-making frameworks that balance cost-effectiveness, equity, and feasibility. This is particularly important in determining trade-offs across service types and populations in the face of fiscal constraints. As demonstrated in the Delphi's use of multi-criteria prioritisation and stakeholder emphasis on vulnerable groups, equity-informed approaches are needed to balance resource allocation fairly.
- *Operationalise inter-sectoral collaboration:* formalise collaboration between key departments, (including Health, Basic Education, Social Development, and Human Settlements) through joint planning, funding, and accountability frameworks. Mental health fora at national and sub-national levels should guide these efforts. This also necessitates leverag-

ing the role of the private sector in the mental health scale-up response through NHI public–private partnerships and pilot initiatives.

- *Enhance monitoring and evaluation systems:* implement the NMHPFSP's 18 priority mental health indicators to track service quality, access, financial protection, and user experience. Strengthen routine data systems and feedback loops to guide continuous improvement.
- *Secure and ring-fence mental health funding:* advocate for dedicated financing mechanisms, such as conditional grants or earmarked NHI allocations, to ensure sustainable resourcing of mental health system reform and service delivery. Financial strategies should also focus on enhancing funding for mental health services from the private sector through increased public–private partnerships.

Conclusion

The South African MHIC is a pivotal resource in guiding policy and NHI reforms towards a more inclusive, efficient and accountable mental health system. The new 2023–2030 NMHPFSP is broadly consistent with the MHIC recommendations, and offers a roadmap for addressing the previous policy's shortcomings, requiring efficient resource allocation and enhancing accountability across healthcare and non-healthcare sectors.

Within the context of NHI, the MHIC carries important implications for the design and execution of plans, particularly regarding mental health benefit entitlements. Global criteria have been outlined by the WHO for decision-making towards the establishment of an essential benefit package.⁴⁰ These criteria have been realised through this investment case as follows: (1) health and economic losses due to MNS conditions are quantified; (2) cost-effective interventions are considered for scale-up; (3) services are re-orientated towards increased PHC care; (4) motivations are provided for the adoption of these interventions in the benefits package for increased financial protection; (5) the budget impact is determined; (6) the feasibility of scale-up is explored; (7) the social and economic impacts of these interventions are quantified, and (8) an inclusive process was undertaken to ensure political acceptability.

By outlining an explicit package of care at each service level and quantifying their resource requirements, the MHIC provides a foundational model for strengthening mental health services in NHI, and offers guidance in designing a rights-based, accessible mental health package. By advocating for the integration of mental health into PHC settings and emphasising early intervention and community-based care, the MHIC aligns with the vision of NHI and UHC for more equitable and efficient healthcare access.

The urgency of addressing mental health within the broader health reform agenda cannot be overstated. NHI represents an unparalleled opportunity to embed mental health as a core component of healthcare services. Insights arising from the development of the MHIC are integral to this process, guiding policymakers in creating an inclusive, efficient, and accountable mental health system.

In conclusion, the MHIC lays the groundwork for embedding mental health as a core component of South Africa's UHC agenda, including through NHI implementation. The opportunity now lies in translating its recommendations into funded action plans, backed by coordinated leadership and shared accountability. By leveraging this moment, and aligning technical, fiscal and policy levers, South Africa can ensure that mental health services become more equitable, efficient, and sustainable for the future.

Abbreviations

Abbreviation	Description
APC	Adult Primary Care
APP	Annual Performance Plan
DALYs	disability-adjusted life-years
DMHST	District Mental Health Specialist Teams
DCP3	Disease Control Priorities Volume 3
GBD	global burden of disease
GDP	gross domestic product
HLYs	healthy life-years
LMICs	low- and middle-income countries
MHCU	mental health care user
mhGAP	Mental Health Gap Action Programme
MHIC	mental health investment case
MNS	mental, neurological and substance-use disorders
MTEF	Medium-term Expenditure Framework
NDoH	National Department of Health
NHI	National Health Insurance
NMHPFSP	National Mental Health Policy Framework and Strategic Plan
PHC	Primary Health Care
ROI	return on investment
SEL	Social and Emotional Learning
UHC	Universal Health Coverage
WHO	World Health Organization

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