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Realizing the Return

Insights from a Decade of Investment Cases
on Noncommunicable Diseases
and Mental Health





Realizing the Return

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The UN Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases brings United Nations system agencies and intergovernmental organizations together to support governments reduce the burden of noncommunicable diseases, including mental health conditions, to meet the goals and targets of the 2030 Sustainable Development Agenda. The Secretariat of the Task Force is at the World Health Organization, Geneva, Switzerland.

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Acronyms and abbreviations

AAP	Ambient air pollution
BMJ	British Medical Journal
CO₂	Carbon dioxide
CSO	Civil society organization
DAH	Development assistance for health
GCC	Gulf Cooperation Council
GDP	Gross domestic product
HAP	Household air pollution
HIV	Human immunodeficiency virus
HLY	Healthy life-year
ICA	Institutional and context analysis
INFF	Integrated national financing framework
LMICs	Low- and middle-income countries
mhGAP	Mental Health Gap Action Programme
NCDs	Noncommunicable diseases
NGO	Non-governmental organization
ODA	Official development assistance
OOP	Out-of-pocket
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary health care
PM	Particulate matter
ROI	Return on investment
SDGs	Sustainable Development Goals
SMART	Specific, measurable, achievable, relevant, and time-bound
SSB	Sugar-sweetened beverage
STEPS	WHO STEPwise approach to NCD risk factor surveillance
UHC	Universal health coverage
UN	United Nations
UNDP	United Nations Development Programme
UNIATF	United Nations Inter-Agency Task Force on the Prevention and Control of Noncommunicable Diseases
UNOSSC	United Nations Office for South-South Cooperation
WHO	World Health Organization
WHO FCTC	WHO Framework Convention on Tobacco Control

Audience and purpose



At a moment of renewed focus on noncommunicable diseases (NCDs), mental health and well-being, this report takes stock of a decade of experience with national investment cases for NCDs, tobacco control, mental health, and related risk factors across more than 60 countries since 2015.

Developed through the Health4Life Fund's South–South Learning Lab for Knowledge Sharing and Innovation, it examines what these investment cases have shown, where they have catalyzed real change, and what is required to overcome barriers and accelerate the implementation of evidence-based recommendations.

The report is intended for governments that have undertaken, or are considering, national investment cases, and for development partners supporting country-led action on NCDs and mental health through bilateral or multilateral channels.

Its purpose is to demonstrate the role of health investments for sustainable development progress, inform priority-setting under fiscal constraint and uncertainty, and set out a strategic framework for translating NCD and mental health commitments into delivery.

Executive summary

Noncommunicable diseases (NCDs) and mental health conditions are among the most consequential and under-addressed constraints on sustainable development today. As the leading causes of premature death, disease and disability worldwide, they limit human capabilities, deepen poverty and inequality, undermine inclusive growth, and strain public systems. This burden is not inevitable. It reflects insufficient and poorly coordinated investment and action across sectors to reduce risk and ensure access to affordable, quality services.

The United Nations Political Declaration on NCDs, Mental Health and Well-being, adopted in December 2025, is the most substantive political declaration on these issues to date. Grounded in equity and integration, it establishes three global “fast-track” outcome targets to be achieved by 2030—150 million fewer tobacco users, 150 million more people with hypertension under control, and 150 million more people with access to mental health care. It also sets ambitious, measurable process targets for national systems, underscoring that progress depends on the strength of policies, institutions, and financing across multiple sectors.

This commitment comes as broader shifts are reshaping the context for action on NCDs and mental health. Amid declining development assistance for health and strained multilateral cooperation, momentum is growing for stronger national and regional ownership of health systems and financing. Recent reform agendas emphasize the importance of sustainable domestic financing and resource mobilization alongside primary health care-led universal health coverage. South–South and triangular cooperation is increasingly recognized as key for sharing solutions, fostering solidarity and innovation, and scaling what works.

These dynamics create both urgency and opportunity for scaling multisectoral and integrated action on health. This includes moving away from reactive and siloed health spending that increases exposure to shocks, crowds out prevention, and locks in high, escalating costs. Greater focus on high-impact, evidence-informed choices is essential. Most fundamentally, health must be treated as a core investment in prosperity and well-being – rather than simply as a social cost – an approach reflected in the UNDP Strategic Plan, 2026–2029.

Countries already have a critical tool for driving systems-change in hand. Since 2015, more than 60 countries have worked with UNDP, WHO, the secretariats of the UN Inter-Agency Task Force on NCDs and the WHO Framework Convention on Tobacco Control, and partners from civil society and academia to develop national investment cases for NCDs, tobacco control, mental health, and related risk factors.

Called for by heads of state and government in the 2018 Political Declaration on the Prevention and Control of Noncommunicable Diseases, these country-led instruments reframe health as a development investment rather than a recurrent cost and bring together health, finance, and other sectors around shared goals.

The cases reveal the scale of the problem and the potential of implementing available solutions. Beyond the human cost of premature death and preventable suffering, the economic burden of inaction is substantial – on average, equivalent to 4.4 percent of GDP for NCDs alone. Yet prevention is a high-value investment. Population-wide measures, such as tobacco control, alcohol control, healthier diets, physical activity, and air pollution reduction, consistently deliver high returns. Early detection and clinical management of cardiovascular disease, diabetes, hypertension, and mental health conditions also deliver positive returns. Together, these and other evidence-based approaches safeguard health and productivity while shifting spending away from inefficient late-stage treatment. As a result, they save millions of lives, avert hundreds of billions in economic losses, and strengthen health systems and fiscal resilience, with strong equity gains.

Equally important, the cases reveal that economic evidence alone does not drive reform. Governance conditions determine whether there will be sustained action. Across countries, political commitment to address NCDs and mental health is often visible, reflected in strategies, plans, and public statements. Yet, frequently, plans lack dedicated financing, enforcement is weak, multisectoral action is fragmented, and commercial interference impedes effective regulation. Where political leadership is strong, however, plans are costed, ministries coordinate, industry interference is constrained, and civil society is meaningfully engaged. In these settings, economic evidence translates into reform, and national investment cases are driving real change.

Countries worldwide report that investment cases have catalyzed reforms in three domains: multisectoral governance, including new or stronger laws, plans, policies, coordination mechanisms, and national campaigns; sustainable financing, including increased budget allocations, strengthened health taxes on tobacco, alcohol, and sugar-sweetened beverages, and leveraged external aid; and health service access and delivery, including integration of NCDs and mental health into PHC, UHC, and HIV/AIDS programming. At the same time, no country has implemented all recommendations, and progress remains uneven and too slow given the scale of the burden.

To deliver on the Political Declaration and the NCD-related targets within Agenda 2030, countries and partners must accelerate and scale implementation of investment case recommendations. Experience from investment cases points to three mutually reinforcing shifts:

- **First, institutionalize NCD and mental health priorities within and across core systems of government.** Countries must translate expressed political commitment into durable mandates, costed plans, and accountability arrangements that endure beyond political cycles. This requires embedding action in development plans, UHC roadmaps, budget processes, and multisectoral mechanisms, with clear roles, enforcement authority, and safeguards against commercial interference.
- **Second, align financing behind prevention and early diagnosis and treatment.** Financing decisions must explicitly account for the macroeconomic and fiscal risks of inaction that investment cases now quantify. Governments must align budgets, fiscal policy, and financing instruments behind NCD and mental health goals. Embracing PHC and UHC, health taxes, and integrated national financing frameworks can shift resources toward high-return measures that protect health, productivity, public budgets, and fiscal space.
- **Third, mobilize partnerships across society and between countries.** Investment cases provide a country-owned, cross-sector evidence base to strengthen coalitions. Parliaments can use them for legislation and oversight. Civil society and communities can anchor their engagement in policy dialogues. Development partners, including multilateral agencies, development banks, and global health initiatives, can use them to align support and reduce fragmentation. South-South and triangular cooperation can accelerate learning and adaptation.

Over the past decade, collaboration across more than 60 countries on NCDs and mental health has generated a substantial body of evidence, catalyzed reforms, and built momentum for further action. With this foundation in place and renewed political focus, realizing the full return for health and sustainable development requires delivery at greater speed and scale, through stronger institutions, financing, and partnerships.



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Introduction

Noncommunicable diseases (NCDs)—including cardiovascular diseases, cancers, chronic respiratory diseases, and diabetes—and mental health conditions such as anxiety, depression, psychosis, and bipolar disorder are now the leading drivers of death, disease, and disability worldwide. NCDs alone account for roughly three quarters of global deaths, while more than 1 billion people live with a mental health condition. An estimated 82 percent of premature NCD deaths (before the age of 70) occur in low- and middle-income countries (LMICs).^{1,2}

Global and national responses have not kept pace with these burdens. Coverage of evidence-based, cost-effective interventions to prevent, treat, and care for people with NCDs and mental health conditions remains low in many countries. Multisectoral efforts to reduce population-level exposure to modifiable risk factors—such as tobacco use, unhealthy diet, physical inactivity, harmful alcohol use, and air pollution—have proven challenging to scale. NCDs and mental health are often not treated as core to primary health care (PHC)-led universal health coverage (UHC).

A core impediment to progress has been a persistent mismatch in financing. For example, median government spending on mental health sits at just 2 percent of total health budgets, a level that has stagnated since 2017.³ Internationally, development assistance for health (DAH) directed toward NCDs and mental health is also chronically low, despite their dominant share of the disease burden. In 2024, less than 2.5 percent of DAH was allocated to NCDs.⁴

Limited action and underinvestment on NCDs and mental health conditions has far-reaching consequences for prosperity, well-being, and sustainable development. NCDs and mental ill-health diminish people's capabilities to learn, work, and participate fully in society; reinforce inequalities; and slow inclusive growth. Each year, they push millions of people into poverty through income loss and out-of-pocket (OOP) health spending, with unpaid care burdens and forgone opportunities falling most heavily on women and girls.⁵ Strains on households, health systems, social protection systems, and public finances are high. Human capital and broader economic losses continue to be measured in trillions, not billions, of dollars.^{6,7}

1 WHO, Noncommunicable-diseases, 2025. Available at: <https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases>

2 WHO, Over a billion people living with mental health conditions – services require urgent scale-up, 2025. Available at: <https://www.who.int/news/item/02-09-2025-over-a-billion-people-living-with-mental-health-conditions-services-require-urgent-scale-up>

3 WHO, Mental Health Atlas, 2024. Available at: <https://iris.who.int/server/api/core/bitstreams/5897b3c7-2848-47a7-ba22-0a7902342a81/content>

4 Institute for Health Metrics and Evaluation (IHME). Development Assistance for Health Database 1990-2025.

5 NCD Alliance, Delivering on Health and Financial Protection for All: Financing Benchmarks for Essential NCD Services and Options for Improving Access to Affordable NCD Medicines, 2025. Available at: <https://ncdalliance.org/resources/delivering-health-and-financial-protection-all-financing-benchmarks-essential-ncd>

6 World Economic Forum, The Global Economic Burden of Non-communicable Diseases, 2011. Available at: <https://www.weforum.org/publications/global-economic-burden-non-communicable-diseases/>

7 PAHO, Major Storm on the Horizon: NCDs and mental health conditions to cost South America trillions by 2050, 2025. Available at: <https://www.paho.org/en/news/15-7-2025-major-storm-horizon-ncds-and-mental-health-conditions-cost-south-america-trillions>

Overall, avoidable NCD and mental health burdens are slowing progress on the Sustainable Development Goals (SDGs) and the pledge to leave no one behind, while weakening the resilience of countries and communities to shocks. These dynamics are documented in the UN Secretary-General's 2025 note on NCDs and mental health (**Box 1**).

Box 1. Rising risks and stalled progress

'Progress on the prevention and control of non-communicable diseases and the promotion of mental health and well-being: note by the Secretary-General'⁸ shows that the absolute burden of NCDs and mental health conditions continues to rise. While some countries have reduced premature NCD mortality through stronger prevention and treatment, overall progress remains insufficient to meet SDG target 3.4: reducing by one-third premature mortality from NCDs and promoting mental health and well-being by 2030. As people live longer with chronic conditions, there will be a growing burden of NCDs and greater demands on health and social systems. Addressing these trends requires a dual focus on preventing avoidable illness and providing quality long-term health and social care.

Progress is stalling due to:

- **Chronic underinvestment:** many national plans lack adequate financing and remain weakly integrated into broader health and development reforms.
- **Low service coverage:** essential prevention and care reach too few people, especially in LMICs.
- **Fragile systems:** pandemics, climate shocks, and conflict have disrupted services and are intensifying vulnerabilities, slowing or reversing progress in many settings.
- **Evidence underutilized:** implementation of cost-effective "best buys" and other recommended interventions remains limited, constrained by political, financial, and institutional barriers, including commercial determinants of health.
- **Widening inequities:** marginalized populations, particularly in small-island, conflict-affected, and fragile settings, face delayed care, catastrophic costs, and preventable deaths.

8 Progress on the prevention and control of non-communicable diseases and the promotion of mental health and well-being: note / by the Secretary-General, 2025. Available at: <https://digitallibrary.un.org/record/4076846?ln=en&v=pdf>

Against this backdrop, in December 2025, Heads of State and Government committed to accelerate action and strengthen accountability, as set out in the Political Declaration of the Fourth High-Level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases and the Promotion of Mental Health and Well-being (**Box 2**).⁹

Box 2. The 2025 Political Declaration: equity and integration as foundations for action on NCDs and mental health

Recognizes that:

- The human and economic costs of NCDs and mental health conditions drive poverty and inequality, disproportionately affecting the poorest and most vulnerable.
- Achieving UHC is essential, through integrated, resilient, and well-financed systems that deliver prevention, promotion, screening, diagnosis, treatment, care, and rehabilitation, anchored in PHC.

Commits to:

- Mobilizing adequate, predictable, and sustained resources for national NCD and mental health responses through domestic, bilateral, and multilateral channels.
- Reducing OOP spending and the risk of impoverishment for people affected by NCDs and mental health conditions.

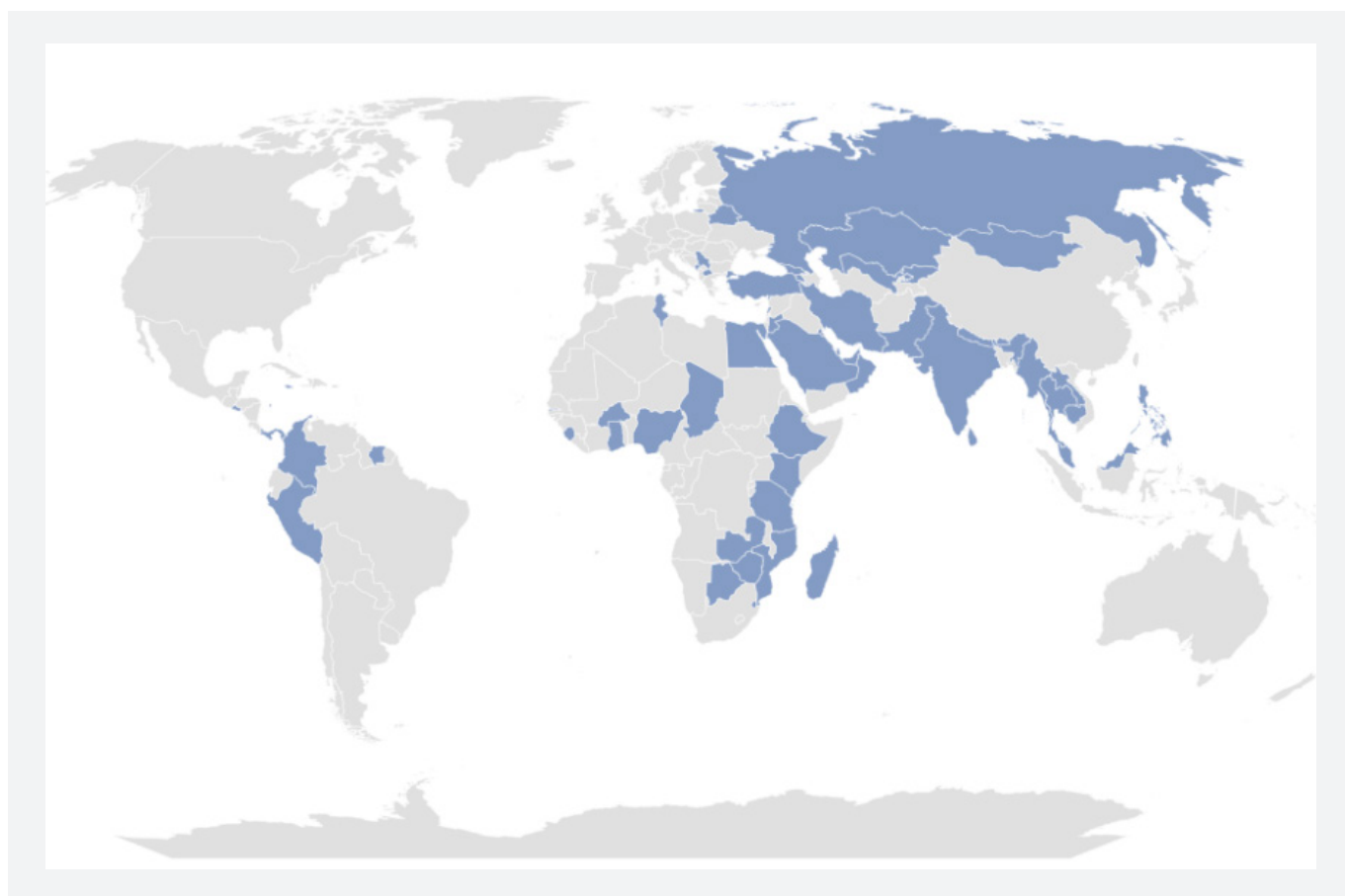
Sets global targets for 2030:

- 150 million fewer people using tobacco; 150 million more with hypertension under control; and 150 million more with access to mental health care.
- At least 80% of countries implementing fiscal, legislative, regulatory, or policy measures to support NCD prevention and control and promote mental health and well-being.
- At least 80% of PHC facilities providing WHO-recommended essential medicines and basic technologies for NCDs and mental health conditions at affordable prices.
- At least 60% of countries adopting financial protection measures that cover or limit the costs of essential NCD and mental health services, diagnostics, medicines, and other health products.
- At least 80% of countries with an operational, multisectoral, integrated policy, strategy, or action plan on NCDs and mental health and well-being.
- At least 80% of countries with an operational NCD and mental health surveillance and monitoring system, in line with national circumstances.

9 WHO, Political Declaration of the High-Level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases and the Promotion of Mental Health and Well-being, 2025. Available at: <https://www.who.int/publications/m/item/political-declaration-of-the-fourth-high-level-meeting-of-the-general-assembly-on-the-prevention-and-control-of-noncommunicable-diseases-and-the-promotion-of-mental-health-and-well-being>

While such commitments are essential, the challenge has long been implementation. Are countries prepared to translate ambition into necessary action? One of the most promising approaches to encourage this has been the development of national investment cases for health. Since 2015, more than 60 countries have worked with UNDP, WHO, the secretariats of the UN Inter-Agency Task Force on NCDs (UNIATF) and the WHO Framework Convention on Tobacco Control (WHO FCTC), as well as other partners including civil society and academia, to develop national investment cases for NCDs, tobacco control, mental health, and related risk factors (**Figure 1**).

Figure 1. Countries that have developed national investment cases for health with support from UN and other partners (2015–2025)¹⁰



The designations employed and the presentation of material on this map do not imply the expression of any opinion whatsoever on the part of the Secretariat of the United Nations or UNDP concerning the legal status of any country, territory, city or area or its authorities, or concerning the delimitation of its frontiers or boundaries.

¹⁰ The NCD and mental health investment cases were delivered through the UNDP–WHO Joint Programme of UNIATF to catalyze multisectoral action for the prevention and control of NCDs and mental health, while tobacco control investment cases were delivered through the Convention Secretariat’s FCTC 2030 project.

National investment cases respond directly to the Political declaration of the Third High-Level Meeting of the General Assembly on the Prevention and Control of NCDs (2018), in which Heads of State and Government committed to “*develop, as appropriate, a national investment case on the prevention and control of non-communicable diseases.*”¹¹ In doing so, they address a central question that countries have long grappled with: what are the social and economic costs of inaction, and what are the returns on investing in prevention and control?

Each investment case combines baseline and forward-looking economic analysis—quantifying the social and economic costs of inaction under existing trajectories and the potential returns from scaling up cost-effective interventions¹²—with an institutional and context analysis (ICA) that examines the political economy factors shaping whole-of-government and whole-of-society action. The cases are country-led and inclusive, engaging ministries beyond health, including finance, planning, labour, and social protection, alongside parliamentarians, civil society, academia, and UN and other development partners. They go beyond technical studies by providing country-specific, nationally owned data, evidence, and recommendations, and by helping to build coalitions for reform.



“The NCD investment case was very important for us. In 2019, we did not have evidence-based data on NCD burden—it was very difficult to convince the deputy minister of finance to invest in this. After the first NCD investment case the ministry of finance changed their view on prioritizing the burden of NCDs.”

—Government official, Independent Evaluation of the UNIATF, 2025¹³

Overall, national investment cases have generated clear arguments and recommendations for scaling up action on NCDs and mental health. Implementation, however, has been partial and uneven. In many countries, cases have catalyzed improvements in multisectoral governance, sustainable financing, and health service access and delivery; in others, progress has been slower, and no country has implemented all recommendations to date. Barriers, including industry interference in policymaking, coordination gaps, capacity constraints, and shifting political priorities, continue to shape both the pace and depth of reform.

11 Political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases: resolution / adopted by the General Assembly, 2018. Available at: <https://digitallibrary.un.org/record/1648984?ln=en&v=pdf>

12 Consistent with established WHO frameworks, including the WHO “best buys” for NCD prevention and control, the WHO FCTC, and the WHO Mental Health Gap Action Programme.

13 UNIATF on NCDs, 2025 Independent Evaluation, 2025. Available at: <https://uniatf.who.int/publications/m/item/2023-joint-independent-evaluation>

A changing global context

The Fourth High-Level Meeting of the UN General Assembly on the Prevention and Control of Noncommunicable Diseases and the Promotion of Mental Health and Well-being recognized that countries will need to advance NCD and mental health priorities in a far more constrained and complex environment. Conflicts, climate shocks, debt distress, and social fragmentation are eroding health system resilience and fiscal space in many countries, while demographic ageing is steadily increasing demand for chronic care and long-term services. Meanwhile, global cooperation for health is under severe strain. Official development assistance (ODA) is tightening and increasingly being redirected toward humanitarian crises and security. DAH has fallen sharply, from US\$80.3 billion in 2021 to US\$49.6 billion in 2024, with just US\$38.4 billion projected for 2025.¹⁴ For NCDs and mental health, these trends risk entrenching existing patterns of underinvestment and widening inequities.

Commercial forces add another layer of complexity. Tobacco and alcohol industries, ultra-processed food producers, and major polluters remain key drivers of NCD risk factors and obstacles to effective regulation. At the same time, digital and technology actors are increasingly shaping information environments, health behaviours, and mental health challenges, creating both new risks and new opportunities for prevention, connection, and service delivery. These dynamics underscore the need for stronger governance and cross-sector accountability.

At the same time, countries are placing greater emphasis on national ownership of health priorities, creating new opportunities to scale up action on NCDs and mental health. Recent reform agendas such as the Lusaka Agenda,¹⁵ the Accra Reset,¹⁶ and the Sevilla Commitment¹⁷ collectively emphasize sustainable, country-led financing and stronger domestic resource mobilization to support UHC and resilient health systems, including PHC and the protection of social spending during crises. As countries advance their responses to NCDs and mental health, South–South and triangular cooperation are increasingly important avenues for sharing solutions, fostering innovation, and scaling what works.

14 Apeagyei, Angela E et al, 2025. Tracking development assistance for health, 1990–2030: historical trends, recent cuts, and outlook. *The Lancet*, Volume 406, Issue 10501, 337–348. Available at: [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(25\)01240-1/abstract](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(25)01240-1/abstract)

15 Future of Global Health Initiatives, *The Lusaka Agenda: Conclusions of the Future of Global Health Initiatives Process*. Available at: <https://futureofghis.org/final-outputs/lusaka-agenda/>

16 The Presidency of the Republic of Ghana, *President Mahama & Global Leaders Launch the Accra Reset at UNGA 2025*. Available at: <https://presidency.gov.gh/president-mahama-global-leaders-launch-the-accra-reset-at-unga-2025/>

17 Sevilla Commitment Fourth International Conference on Financing for Development. Available at: https://financing.desa.un.org/sites/default/files/2025-08/FFD4%20Outcome%20Booklet%20v4_EN%20-%20spread.pdf

In this evolving context, national investment cases are not a silver bullet, but they are more consequential than ever. By articulating the socio-economic case for health and well-being, aligning health and development priorities, and directing scarce resources toward cost-effective action, they offer governments a practical tool for decision-making under constraint. To realize this potential, it is essential to take stock of the past decade of investment case experience and to assess what is required to strengthen their uptake and impact.

Scope of the report

This report synthesizes a decade of national investment cases on NCDs and mental health: what they have demonstrated and how they have catalyzed action. Drawing on completed cases from more than 60 countries, alongside findings from two global cross-country surveys conducted in 2024 and 2025, it distills key economic and governance insights, examines where and how investment cases have delivered impact, and identifies what is required to deepen implementation in line with global goals.

Other considerations related to investment cases remain important but are beyond the scope of this report. These include defining criteria for when or where investment cases should be undertaken, providing detailed interpretive guidance on their use or limitations, and reviewing investment case methodologies, including to better capture gender, equity, rights, and broader measures of well-being beyond GDP.

2

Economics

What the numbers tell us

This section presents economic findings from national investment cases on NCDs, tobacco control, air pollution and mental health, developed with UN and partner support between 2015 and 2025. It provides a cross-country synthesis of the losses and gains associated with different response choices, and how these shape sustainable development outcomes.¹⁸ Three key messages stand out:



The hidden cost of inaction

The cost of inaction is immense. Failure to adequately address NCDs and mental health challenges erodes health and well-being, productivity, and fiscal space.



The returns from prevention and early treatment

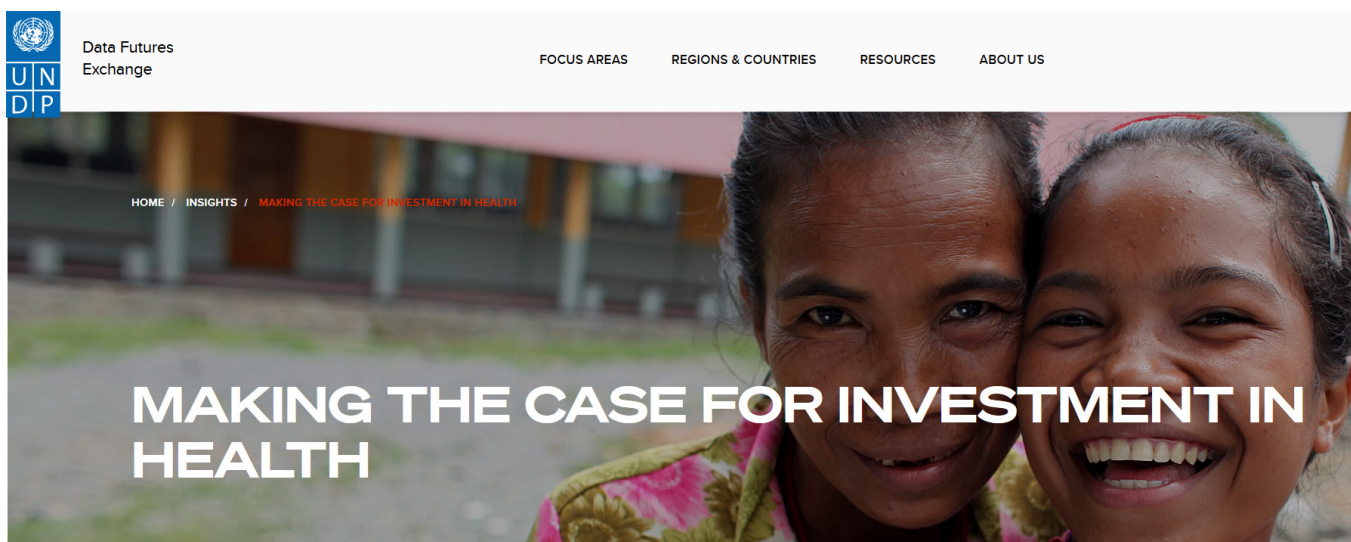
Prevention and early, effective care are among the highest-value investments available to governments. They preserve health and productivity and avert inefficient spending on avoidable late-stage treatment.



Equity and human rights dividends

Scaling effective responses can yield strong equity and human rights dividends. Expanding access to prevention and care generates broader benefits, from financial protection and poverty reduction to cleaner air and improved mental well-being.

Results, methods and interventions for each investment case in this report are available on [Making the Case for Investment in Health](#), a UNDP Data Futures Exchange platform.



18 All monetary amounts throughout the economics section are in US\$ unless otherwise noted. All figures subject to rounding.



The hidden cost of inaction

NCDs and mental health conditions amount to a slow-moving economic shock that erodes well-being, productivity, and fiscal space year after year. Their effects on individuals and families can be sudden and devastating, but at the national level the damage accumulates gradually. Unlike pandemics, conflicts, or financial crises, this burden is often politically invisible, diffused across health, education, labour, and development, and unfolding beyond a single government cycle. Investment cases show the consequences: diminished human potential and a scale of economic burden that rivals other crises but receives far less urgency.

Across 22 national NCD investment cases analyzed, the economic burden of NCDs, expressed as a share of GDP, averaged 4.4 percent (ranging from 1.1 to 9.7 percent).¹⁹ No country—regardless of income—is spared. In Cambodia, the estimated economic burden amounts to 6.6 percent of GDP each year, while in Qatar it is estimated at 2.7 percent, equivalent to about US\$2,700 per person in foregone output annually.

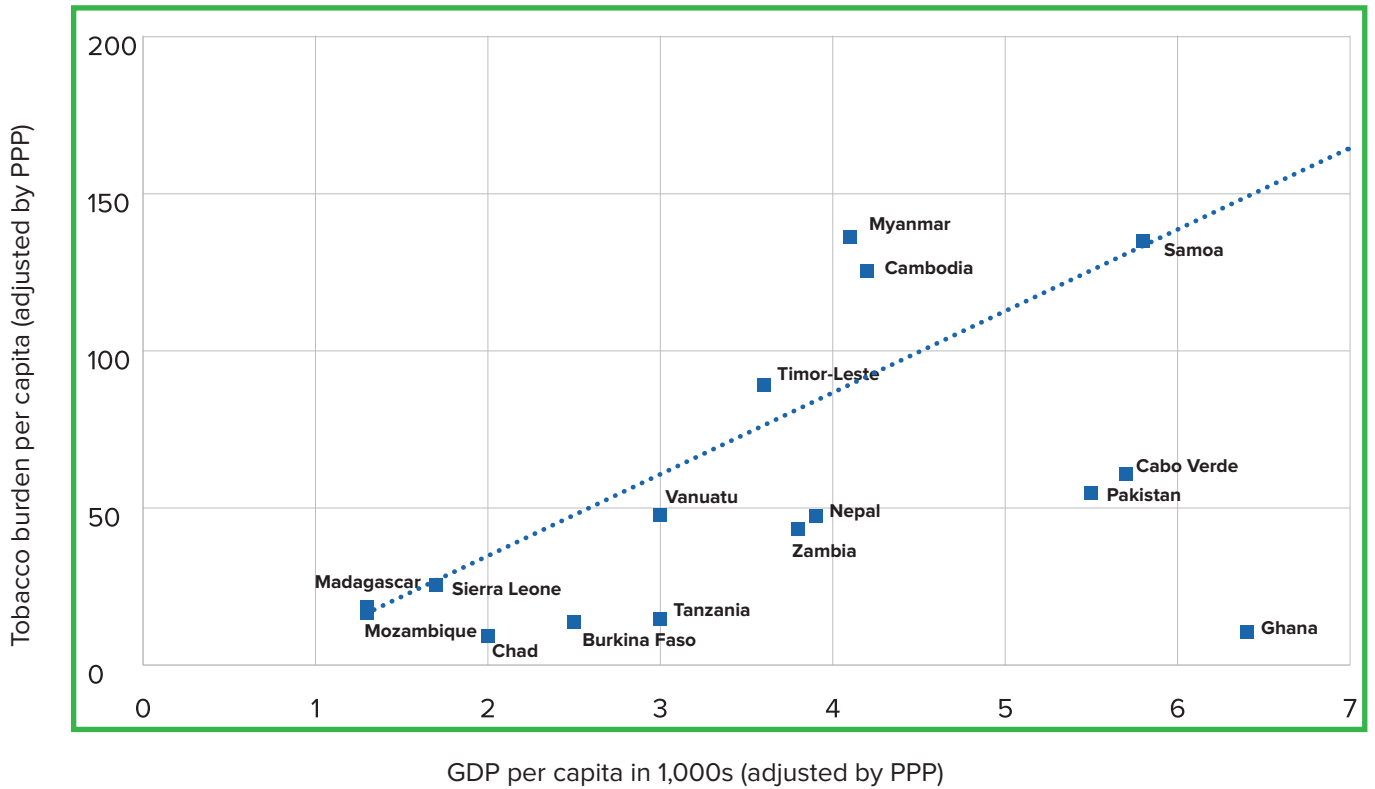
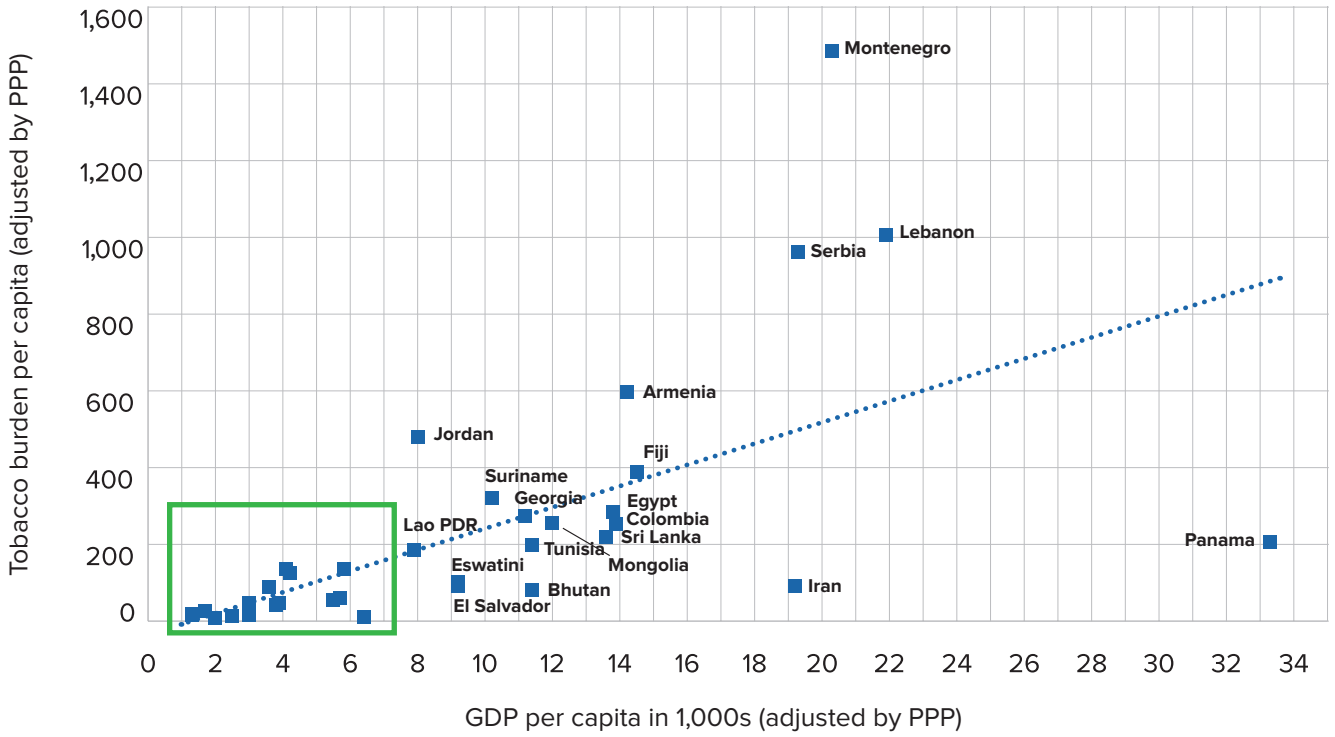
Across 36 national tobacco control investment cases, tobacco use is estimated to impose an average economic burden equivalent to 2 percent of GDP each year.²⁰

Countries with higher GDP per capita generally experience greater per-capita tobacco-related losses, reflecting higher forgone economic output and, in many cases, higher healthcare expenditures. Some countries diverge from this pattern, acting as outliers mainly due to differences in tobacco use prevalence and policy context. For example, Montenegro sits well above the trend line, consistent with relatively high tobacco use (~40 percent of adults). By contrast, Panama falls below the trend line: adult smoking prevalence is low (~5 percent) alongside strong tobacco-control laws (**Figure 2**).

19 Two of 24 completed NCD investment cases did not include economic burden analyses; average represents unweighted arithmetic mean. Economic loss estimates expressed as a share of GDP in investment cases are based on cost-of-illness methods that report healthcare expenditures and productivity losses as components of economic burden. Because healthcare spending contributes to GDP while productivity losses reflect foregone output, these combined components should not be interpreted as net GDP loss (see Chisholm et al., Economic impact of disease and injury: counting what matters, *BMJ*, 2010). Investment cases express the economic burden as a share of GDP to convey scale of impact, not to estimate net GDP effects.

20 Average represents unweighted arithmetic mean.

Figure 2. Tobacco-related economic burden tends to rise with GDP per capita. Each dot represents one national tobacco control investment case. Dashed lines show fitted linear trendlines.



Air-pollution investment cases also reveal major economic impacts:

- In Ethiopia, the estimated economic burden of household air pollution (HAP) amounts to about US\$8 billion annually (4.2 percent of GDP).
- Mongolia faces an annual economic burden of US\$1.2 billion (7.6 percent of GDP) from HAP.
- In India, the annual economic toll of ambient air pollution (AAP) across two cities, Amritsar and Gurugram, reaches US\$11.3 million.

Across seven national mental health investment cases (The Gambia, Jordan, Kenya, Kyrgyzstan, the Philippines, Uzbekistan, and Zimbabwe), the estimated annual economic burden is equivalent to 0.4–1 percent of GDP. For the Philippines, for example, the estimated economic burden (equivalent to 0.4 percent of GDP) amounts to over US\$1 billion annually.

The economic burden of NCDs is inseparable from their human toll. In nearly one-third of countries that have undertaken NCD investment cases, the probability of dying prematurely from one of the four main NCDs is equal to or exceeds 25 percent (**Table 1**). High premature mortality often coincides with large economic losses. This convergence of human loss and economic impact depletes human capital, undermines fiscal resilience, and reinforces the urgency of prevention and early care as both economic and public health priorities.

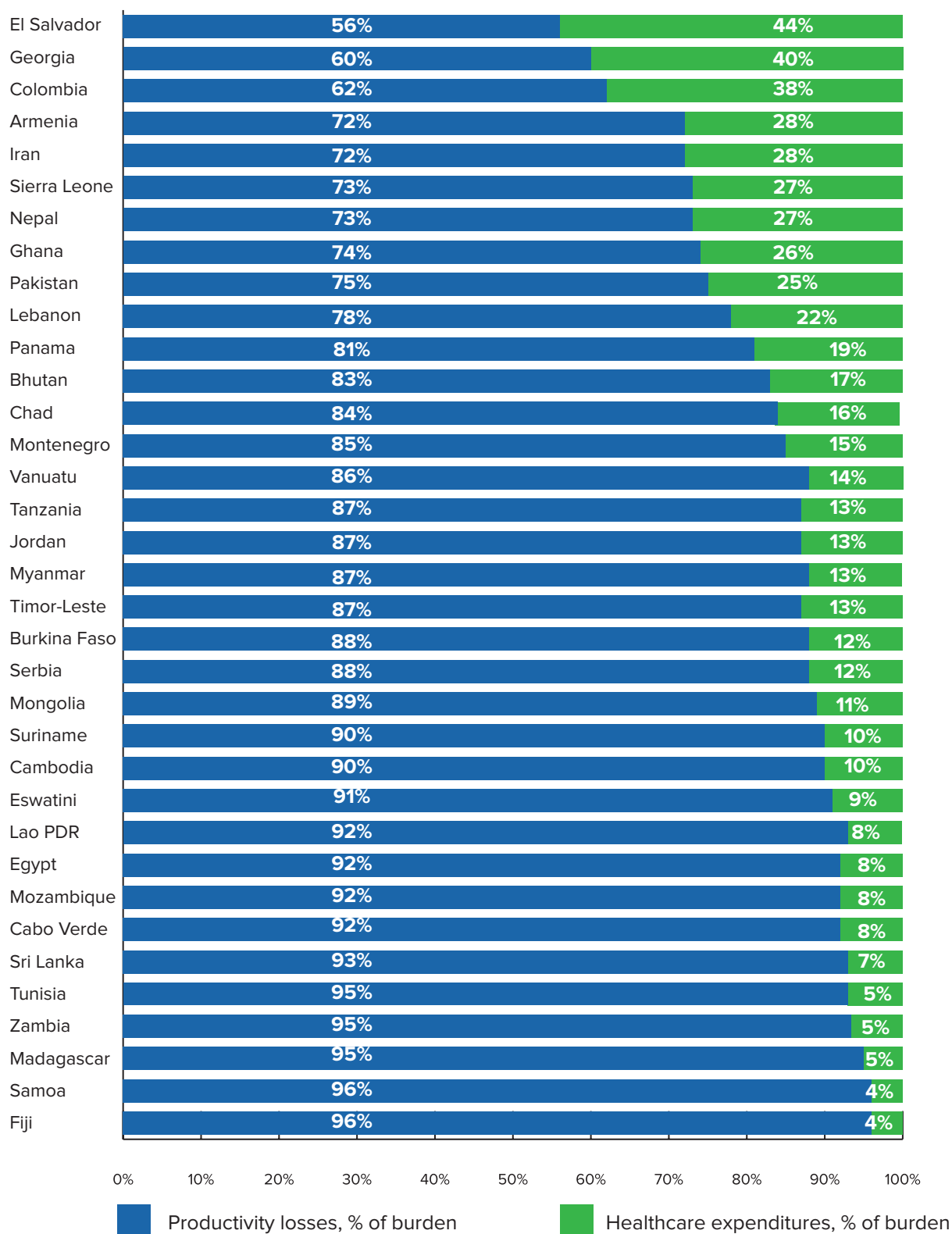
Table 1. Countries facing the highest risk of premature NCD mortality also experience some of the largest economic losses as a share of GDP.

Country	Premature NCD mortality risk (%)	NCD burden % GDP
Philippines	27	4.80
Kazakhstan	27	4.50
Belarus	26	5.40
Uzbekistan	25	4.70
Georgia	25	6.20
Russian Federation	25	3.90

Direct healthcare costs represent only a fraction of the economic toll of poor health. Productivity losses—mainly driven by premature mortality, followed by absenteeism, and reduced on-the-job performance (presenteeism)—account for the largest share of the measured economic impacts. Across tobacco control investment cases, productivity losses average 83 percent of total costs, compared with 17 percent from direct healthcare expenditure. The share ranges from 56 percent in El Salvador to 96 percent in Fiji (**Figure 3**). Countries are absorbing productivity losses equivalent to entire industries due to a product whose harms are entirely preventable. **Figure 3** illustrates where economic impacts are concentrated: productivity losses consistently exceed direct healthcare spending.

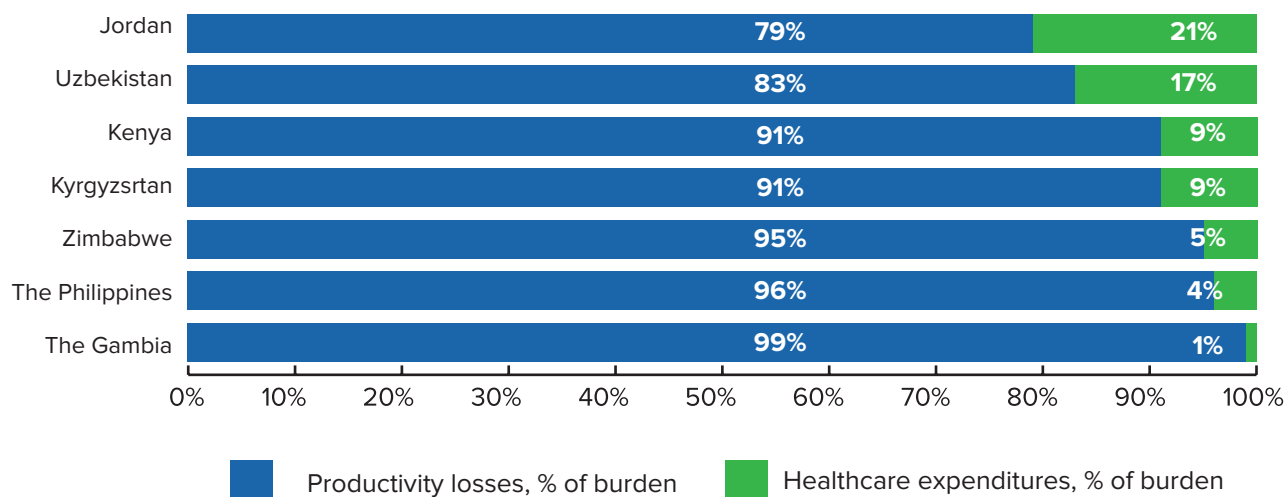
Much of this loss reflects lives cut short: on average, 59 percent of tobacco-related deaths occur before age 70. In Madagascar, that figure reaches 82 percent.

Figure 3. Composition of the economic burden of tobacco use: productivity losses vs. healthcare expenditure



For mental health, this pattern is even starker: around 90 percent of the total measured economic impact stems from lost productivity, with a far smaller share from healthcare expenditure (**Figure 4**).

Figure 4. Composition of the economic burden of mental health conditions: productivity losses vs. healthcare expenditure



Key insight

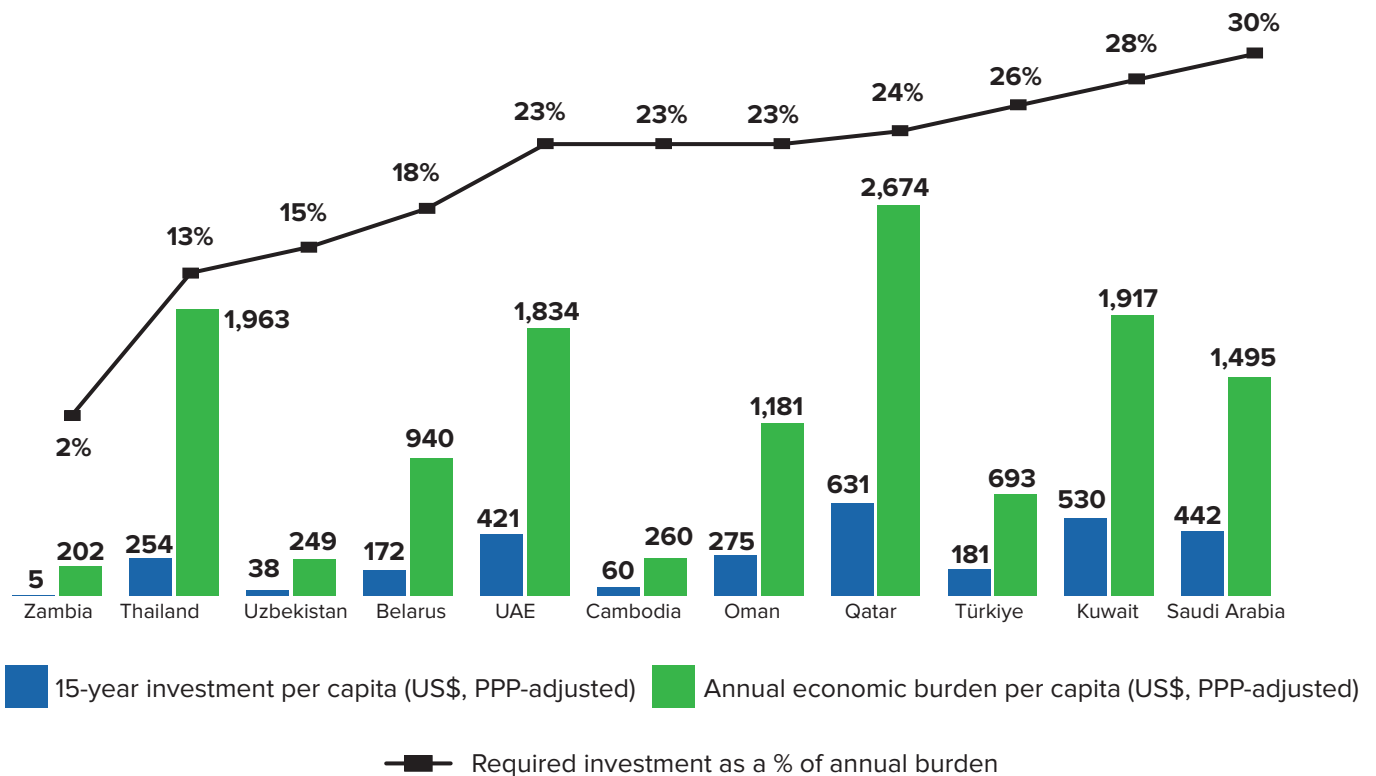
Instead of investing more in prevention and early care, countries are absorbing far higher costs from late-stage treatment, lost productivity, and premature deaths. This reduces fiscal flexibility and the capacity to invest in other priorities such as education, infrastructure, and climate resilience. These burdens extend well beyond the healthcare system to households, workplaces, and schools, including through increased caregiving demands that often fall on women and girls. Behind every percentage point of GDP are people and families living the consequences.

2 The returns from prevention and early treatment

The scale of loss makes the case for action clear and prevention offers one of the smartest investments in people and economies alike. It protects health, preserves productivity, and delivers returns that far exceed its cost. Across 23 national NCD investment cases, full implementation of recommended interventions could save 9.5 million lives and prevent US\$312 billion in economic losses over 15 years. Across 36 national tobacco control investment cases, full implementation of WHO FCTC demand-reduction measures could save 2.3 million lives and US\$90 billion over the same period. For mental health, scaling up priority interventions over ten years could add more than 1.5 million healthy life-years (HLYs) and generate US\$7.2 billion in economic gains.

Prevention is consistently cheaper than maintaining the status quo. In most NCD investment cases, the total 15-year cost of prioritizing prevention is far lower than the annual economic burden of NCDs. The contrast is clearest in Zambia, where the per-capita cost of implementing the NCD interventions over 15 years is just US\$5, compared with an annual per-capita burden of US\$202. The figure below highlights the countries in which the investment in NCD prevention constitutes the smallest proportion of the annual economic burden.

Figure 5. The cost of preventing NCDs vs. the cost of inaction



The same pattern holds across tobacco control investment cases: in every country, the total cost of implementing recommended measures over 15 years is smaller than the economic burden incurred in a single year. On average, the 15-year investment amounts to just 13 percent of a single year's losses, and in countries such as Colombia and Myanmar, less than 2 percent.

The returns on investment (ROI) are striking. Across 23 national NCD investment cases, interventions consistently demonstrate strong economic payoffs over 15 years:²¹

- Salt reduction packages deliver average returns of 31:1, meaning that every dollar invested can yield a US\$31 return.
- Tobacco control achieves an average ROI of 9:1, peaking at 45:1 in Kazakhstan and 31:1 in Belarus.
- Alcohol control policies return 4.8:1 on average, while physical activity promotion yields 5.6:1.
- Clinical interventions focused on early detection and management also show positive returns in several countries; for example, cardiovascular diseases and diabetes clinical interventions deliver ROIs of 6:1 in Qatar, 2.7:1 in Saudi Arabia, and 1.25:1 in Thailand. In Zambia, hypertension treatment alone generates an ROI of 4.6:1.

Box 3. What effective prevention looks like

Effective prevention consists of two mutually reinforcing tracks:

- *Population-level prevention* curbs exposure to tobacco, alcohol, unhealthy diet, physical inactivity, and air pollution.
- *Individual-level prevention and early management* support early detection and risk reduction—through screening, counselling, tobacco cessation support, and continuous care in PHC facilities—helping prevent progression and reducing costly hospital treatment and possible long-term care.

Population-wide policies deliver exceptionally high returns at relatively low cost. In Türkiye, for example, salt reduction and tobacco control could save over 500,000 lives over 15 years, achieving half of all deaths averted in the investment case at just 10 percent of total investment. Meanwhile, clinical interventions, though less 'economically efficient', remain cost effective, provide quick and substantive wins for reducing burdens, and are essential for equity and the right to health. Countries must advance both tracks to protect health and support inclusive development.

21 Average ROIs are presented to illustrate the overall magnitude of returns. They are not for direct comparison across countries, as they are influenced by factors such as baseline implementation levels and cost structures, which vary substantially across settings. NCD intervention packages modeled in investment cases also differ by country; averages are calculated only from those that included the respective intervention package. Packages draw on WHO-endorsed frameworks, including SHAKE for salt reduction, SAFER for alcohol control, and measures consistent with the WHO FCTC.

Tobacco control cases demonstrate the extraordinary ROIs of interventions to reduce tobacco use (average of 77:1, with the highest estimated ROI found in Georgia at 357:1). Measures such as taxation, advertising bans, and smoke-free laws require minimal fiscal outlay yet unlock billions in productivity gains and health savings.

For air pollution, returns on action are equally strong:

- In Gurugram and Amritsar, India, shifting industries to cleaner fuels over 10 years could yield ROIs of 10:1 and 8.6:1 respectively, while averting death and disease (AAP).
- In Mongolia, four interventions to reduce AAP—introducing gas-electric stoves, converting power plants, reducing open fires, and curbing road transport emissions—could prevent US\$671 million in economic losses and save 12,600 lives over a 31-year period.
- In Ethiopia, transitioning 5.8 million households to cleaner cookstoves could save US\$2.4 billion and 6,000 lives over just 10 years. This generates a 7.2:1 return on public spending when considering health, time, and environmental benefits, rising to 20.7:1 when including household fuel savings.

For mental health, investments are also highly cost-effective:

- Depression treatment yields a 10:1 return in Uzbekistan over 10 years, and 8.8:1 in Kyrgyzstan and 4.6:1 in Suriname over 15 years.²²
- School-based social and emotional learning delivers a return of 4.2:1 over 20 years in the Philippines.
- Epilepsy treatment in Uzbekistan generates a 23:1 return over 10 years.
- A pesticide ban in Zimbabwe to prevent suicide deaths yields a 5.4:1 return over 10 years, rising to 15.4:1 over 20 years.



Key insight

NCD prevention and control, alongside the promotion of mental health and well-being, are among the most economically sound investments available to governments. While prevention and early care require upfront resources and do not eliminate health and care costs over the life course, they change when and how those costs arise. This reduces fiscally disruptive health spending on late-stage illness and shifts expenditure to later ages from a healthier, more productive economic base.

²² Suriname is excluded from the aggregate analysis due to non-disaggregated NCD and mental-health estimates.

Box 4. Returns across health investments

Many NCD and mental health interventions deliver high returns, consistent with other globally recognized, high-value health investments. For example, malaria prevention in 29 African countries (2023–2030) has been estimated to yield US\$48 for every US\$1 invested,²³ while Gavi-supported childhood vaccines in 94 LMICs (2021–2030) deliver US\$19.8 per US\$1.²⁴ Because methodologies differ, these figures are not directly comparable, but the pattern is clear: addressing NCDs and mental health conditions delivers similarly strong returns and represents excellent value for money alongside other health investments.



Photo: © UNDP

23 Shretta R and Ngwafor R, 2023. Benefits and Costs of Scaling up Coverage and Use of Insecticide Treated Nets, An Investment Case for the Scale up of Insecticide Treated Nets and the use of all nets, halfway into the SDG targets, University of Oxford. Available at: <https://copenhagenconsensus.com/sites/default/files/2023-12/Malaria%20Best%20Investment%20Manuscript%20230310.pdf>

24 Sim, S, et al, 2020. Return on investment from immunization against 10 pathogens in 94 low-and middle-income countries, 2011–30. Health Affairs, 39(8), 1343-1353. Available at: <https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00103>



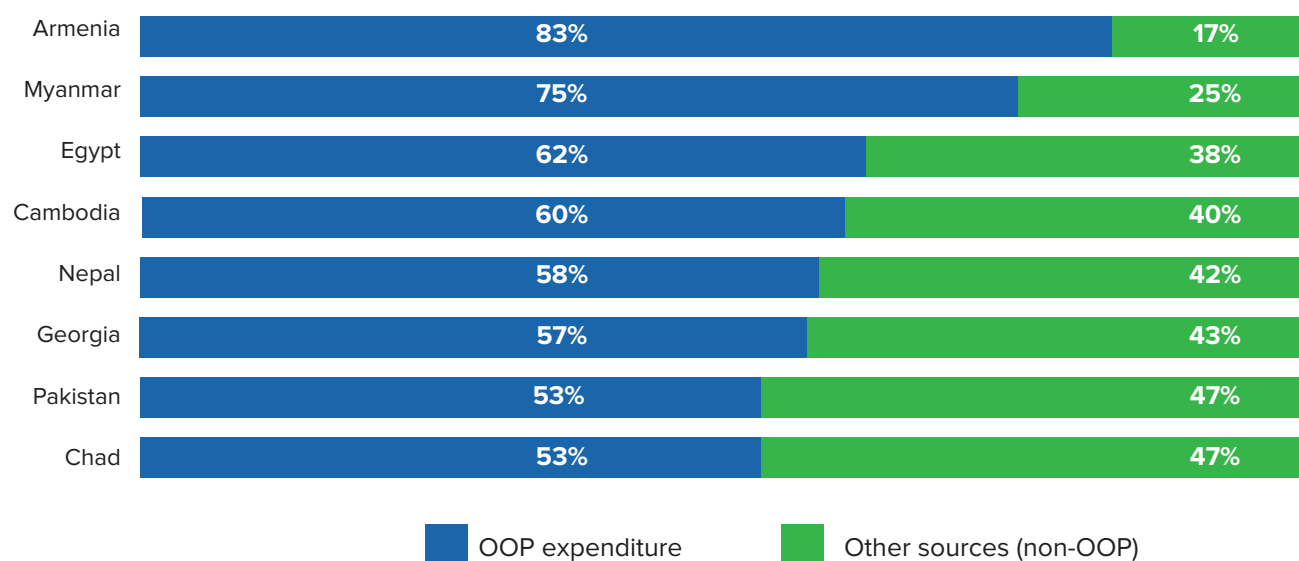
Equity and human rights dividends

When countries invest in prevention and early care, the returns extend beyond efficiency, delivering measurable gains for equity and human rights.

Investing in equitable delivery strengthens impact and inclusion. Recent NCD investment cases increasingly account for the practical steps needed to ensure services reach those often left behind. Examples include community-based outreach, targeted training for PHC teams, facility supervision, and multisectoral coordination. By costing such elements, the analyses provide a more realistic picture of what it takes to translate expanded coverage into equitable access. In Malawi, equity was addressed through an integrated primary care delivery model embedding NCD services into routine PHC and ensuring delivery by trained medical officers and the provision of essential supplies such as insulin and monitoring equipment. Under this scenario, expanding coverage from 25 to 80 percent could generate over US\$2 billion in social returns over 10 years, more than nine times the investment.

Prevention is a powerful instrument for promoting financial protection. By averting illness and the costs that follow, prevention helps shield households, especially the poorest, from catastrophic health spending. National tobacco control investment cases illustrate this clearly: on average, OOP spending accounts for 35 percent of tobacco-attributable healthcare expenditures, ranging from 9 percent in Vanuatu to 83 percent in Armenia. Even when the denominator is expanded to total economic impacts, including lost productivity as well as healthcare costs, OOP spending remains substantial at around 6 percent on average. Across all countries analyzed, households spend more than US\$2.6 billion each year on medical care for tobacco-attributable diseases. These costs often push families into debt and financial hardship. **Figure 6** shows the countries in which households pay more than half of tobacco-related health costs, underscoring the equity implications of tobacco control.

Figure 6. Countries with the highest OOP expenditure (as a percent of total healthcare spending for tobacco-related diseases)



Health taxes are among the most effective and equitable tools for health and development.

By discouraging harmful consumption, especially in poorer populations, where price sensitivity is highest, they address health and economic inequities while generating revenue for development. In tobacco control investment cases, a modeled scenario of a uniform 30 percent increase in cigarette prices across 19 LMICs found pro-poor, progressive results. In all but one country, the steepest decline in smoking was projected in the poorest quintile. One-third of all lives saved would occur in this quintile, which would bear only 12 percent of the additional tax paid. In Ghana, for example, half of lives saved from higher tobacco prices would be in the lowest-income quintile.²⁵

Box 5. Health taxes can finance PHC

Health taxes not only prevent disease but transfer economic power from harmful industries to public budgets. In the Gulf Cooperation Council (GCC) region, the cost of a selected package of PHC clinical services, including NCD services, has been estimated at US\$5.7 billion annually.²⁶ Meanwhile, stronger taxes on tobacco, alcohol, and sugary drinks could raise US\$57 billion in additional revenue between 2025 and 2029^{27,28} — enough to fund 10 years of this PHC package while advancing prevention and fiscal sustainability.

25 Spencer G, et al, 2023. Equity implications of tobacco taxation: results from WHO FCTC investment cases. *Tob Control*. 2024;33(Suppl 1):s27-s33.2024. Available at: <https://pmc.ncbi.nlm.nih.gov/articles/PMC11103284/>

26 UNDP, Costing of Primary Healthcare Arrangements in six Gulf Cooperation Council Countries: A Synthesis Report, 2024. Available at: <https://www.undp.org/arab-states/publications/costing-primary-healthcare-arrangements-six-gulf-cooperation-council-countries-synthesis-report>

27 Under a moderate scenario, the model projects a 50 percent increase in tobacco retail prices and a 20 percent increase in the prices of sugar-sweetened beverages and alcoholic drinks

28 UNDP, Strengthening taxes on unhealthy products in the Gulf States, 2024. Available at: <https://www.undp.org/arab-states/publications/strengthening-taxes-unhealthy-products-gulf-states>

Mental health investments deliver equity gains by expanding social and economic participation, inclusion, and capabilities—core foundations of resilient development. Evidence from mental health investment cases shows that the social and developmental value of mental health interventions is substantial, including strengthened human rights, improved social cohesion, and more dignified, person-centered care. Expanding community-based and primary care mental health services also reduces inequities in access and OOP spending and supports participation in education and work. While many of these gains are not yet captured in economic models, they point to a shift toward a more inclusive and rights-respecting model of development that leaves fewer people behind.

Tackling air pollution generates simultaneous gains for equity and climate resilience, alongside economic welfare. In Ethiopia, women face carbon-monoxide exposure from traditional stoves that is eleven times higher than men's, reflecting greater time spent indoors; in Mongolia, women spend up to five hours a day on fuel-related tasks; and in India (Gurugram and Amritsar), women are more likely than men to walk or use informal transport, modes associated with 30–40 percent higher exposure to PM_{2.5}. Cleaner cooking and safer transport reduce these risks, free time for education and paid work, and lower household and population-wide health burdens. Clean air interventions also support climate goals. Ethiopia's investment case shows that scaling cleaner cookstoves could prevent the harvest of 12 million trees annually, cutting emissions equivalent to 20 percent of its 2030 CO₂ target.



Key insight

The benefits of NCD and mental health interventions extend far beyond efficiency. When designed and delivered inclusively, they generate equity and human rights gains by expanding access to care, reducing household financial exposure, strengthening human capabilities and social cohesion, and addressing unequal health and environmental risks. These gains can be achieved while maintaining strong economic returns.

3



Governance

The politics that shape reform

The economics are clear: inaction is costly, and prevention pays. But ROI analyses alone do not drive change. Across countries, ICAs show that progress is shaped by the interplay of governance, incentives, and economic evidence. Where political leadership is strong, plans are costed, ministries coordinate, industry interference is addressed, and civil society is meaningfully engaged, economic evidence is far more likely to translate into reform.



Each investment case includes an ICA, an X-ray of governance systems and political conditions at the time of development. ICAs map the stakeholders, mandates, incentives, and power dynamics that determine whether evidence becomes action. They expose barriers beneath the burden, such as competing priorities, weak accountability, and industry interference in policymaking. They also identify leverage points such as policy windows, champions, and development narratives that can drive reform.

This section of the report examines what ICAs collectively reveal about the governance conditions that enable or impede action on NCDs and mental health. Many of the findings and conclusions from these ICAs are reflected in the 2025 Political Declaration on NCDs, Mental Health, and Well-being.

Political commitment has outpaced institutionalization

The ICAs reveal that political commitment to NCDs and mental health is often present but inconsistently followed through. NCDs and mental health were commonly included in health sector strategies and UHC frameworks, and in some countries also referenced in longer-term national development plans, often accompanied by political statements of support from senior government figures. As a result, they were better positioned on national health and development agendas than in 2011, at the time of the First High-Level Meeting of the General Assembly on the Prevention and Control of NCDs. Yet while NCDs and mental health were frequently recognized as priorities, implementation, enforcement, and financing across ministries remained uneven.

Examples reflecting challenges in institutionalization include:

- Bhutan: Policy shifts, including the 2021 amendment to the Tobacco Control Act that eased restrictions and taxation, were found to have weakened enforcement and contributed to rising tobacco use.
- Thailand: The Ministry of Public Health led most initiatives, but policy commitment and implementation from non-health ministries requires strengthening to sustain implementation.
- Zambia: Enforcement capacity was noted as weak despite multiple statutory instruments.

Smoke-free laws, advertising restrictions, and the Liquor Licensing Act existed on paper but were poorly implemented due to limited resources and fragmented oversight. Industry lobbying further complicated reform, including attempts to dilute the Tobacco Control Bill and influence tax policy.

- India, Ethiopia, and Mongolia: National environmental and air-pollution programmes faced financing and coordination shortfalls, illustrating how plans often exceeded dedicated resources and administrative capacity.

Opportunities to strengthen institutionalization were identified in the ICAs, including by linking actions with broader development priorities. In Bhutan, tobacco control was framed within the country's Gross National Happiness philosophy, treating tobacco use as incompatible with national well-being. In Ethiopia, clean energy cookstoves were linked to SDGs on health, climate action, and rural livelihoods, benefiting women and children. In the Philippines, the integration of NCD prevention into national health reforms, including PhilHealth's primary care benefit package and the Department of Health's Medicines Access Program, created openings to position NCDs as part of the country's wider social protection agenda.



Key insight

For sustained policy change and impact, political commitment should extend across parties and be anchored in durable governance arrangements: clear mandates, coordinated institutions, adequate financing, and accountability mechanisms that outlast political cycles.

Emerging governance frameworks lack consistent effectiveness

Recognition of the need for whole-of-government approaches for the prevention and control of NCDs and improving mental health is now widespread, but the strength of institutional arrangements to put this into practice and monitor progress varies.

Countries are increasingly using coordination bodies, with different degrees of impact. In the United Arab Emirates, Thailand, and Oman, multisectoral mandates and monitoring functions provide more durable platforms for collaboration, with their reach still evolving. Barbados' National NCD Commission and Bahrain's Multisectoral National Coordination Mechanism on NCDs signal institutional commitment, though their maturity and influence vary. On tobacco control, Ghana's Tobacco Control Inter-Agency Coordinating Committee convenes relevant ministries alongside civil society, while Jordan's National Coordination Mechanism offers a model for sustained coordination and oversight. These examples show that effective coordination structures require broader institutional capacity and follow-through.

Legal frameworks can either enable or constrain multisectoral action. Kenya's experience illustrates

how outdated legislation can impede coordination, but also how reform can catalyze change. The Mental Health (Amendment) Act of 2022 replaced the 1989 law, introducing stronger rights protections and clearer institutional mandates, although implementation and resourcing remain uneven. The reform builds on earlier advances, including constitutional recognition of the right to health and efforts to integrate mental health into general health services. Kenya's shift away from often custodial forms of inpatient treatment toward a more rights-based, community-oriented, and multisectoral approach requires effective financing and implementation.

Even where national frameworks exist, local delivery systems frequently lack the resources and authority to operationalize them. In Malawi and Suriname, many NCD reforms have remained concentrated in urban centres, with limited mechanisms or resources to extend implementation and enforcement to rural districts. Tobacco control ICAs confirmed the importance of subnational capacity: in Sri Lanka, smoke-free zones often depended on provincial health units, while in Tunisia, enforcement mechanisms remained largely unfunded despite national smoke-free regulations and the continued allowance of designated smoking areas.



Key insight

Multisectoral action depends on governance arrangements with clear authority, defined mandates, strong links to planning and budgeting processes, relevant legislative and enforcement bodies, and the convening power to make whole-of-government and whole-of-society engagement at national and local levels routine.

Political champions catalyze reform by elevating health to centres of power

The ICAs show that while ministries of health lead NCD and mental health responses, their efforts are often constrained by limited budgets and weak cross-sectoral reach. Progress is more likely when influential political actors help elevate NCDs and mental health from a technical concern to a broader development issue. In several countries, high-level champions increased visibility, strengthened interministerial coordination, or backed more decisive measures such as taxation—but these gains did not automatically overcome underlying resource or implementation constraints.

Head-of-state and head-of-government engagement is essential for promoting NCDs and mental health as a political priority. In Thailand, positioning NCD governance within the Prime Minister's Office—with the National Health Commission chaired by the Prime Minister or Deputy Prime Minister—raised the profile of NCDs and supported stronger cross-ministerial coordination. In Ethiopia, the Prime Minister's engagement helped situate NCD goals within broader health

reforms, demonstrating how leadership at the executive level can sustain visibility and momentum.

Leaders in the ministry of finance are crucial allies. In Iran and Sri Lanka, cost-of-inaction analyses developed through tobacco control investment cases supported ministries of finance in backing tobacco control reforms, illustrating how economic framing can help bring influential actors into the agenda.

High-level patrons and advocates also play influential roles. In Bhutan, Royal Advisory Councillors supported bans on cigarette sales on moral and cultural grounds, helping advance tobacco control. In Jordan, Royal Patronage helped elevate mental health as a priority in partnership with WHO and national stakeholders.



Key insight

Ministry of health leadership is necessary but not sufficient. When NCDs and mental health are elevated to centres of political power, governance and action gain greater authority, visibility, and durability.

Industry influence is pervasive and politically potent

Across the ICAs, commercial actors—especially in tobacco, alcohol, ultra-processed foods, and fossil fuels—emerged as major obstacles to reform. Their playbook is strikingly consistent: lobbying legislators, threatening litigation, funding misinformation, and framing regulation as a threat to growth, jobs, trade, or revenue. These tactics have diluted fiscal measures or stalled regulations, even when strong economic evidence supported action.

Fiscal measures are prime targets. In Zambia, Cambodia, and the Philippines, industry pressure weakened, reversed, or delayed tobacco tax reforms. In the Philippines, similar tactics affected sugar-sweetened beverage taxes, with food and beverage industry actors using congressional lobbying, media campaigns, and narrative framing to oppose a sugar-sweetened beverage (SSB) tax and marketing restrictions for children. In Jamaica, tobacco industry representatives engaged decision-makers to convey erroneous economic arguments not based on empirical evidence, particularly around jobs and illicit trade, to block stronger regulation. Influence from food-sector actors was also noted, including through their participation in key economic bodies and health funds.

Structural reliance on fossil fuels has produced long-standing harmful exposures. In India, Ethiopia,

and Mongolia, dependence on coal, biomass, and fossil-fuel transport has sustained levels of air pollution that drive NCDs. Multisectoral action is required to address this.

Progress requires shifting the balance of power. In Thailand, advances in tobacco taxation were enabled by strong legal mandates, such as establishing the Thai Health Promotion Foundation by statute, earmarking revenues through a 2 percent surcharge on tobacco excise, and the mobilization of advocacy coalitions that helped counter industry interference. ICAs across countries noted the importance of Parties to the WHO FCTC implementing Article 5.3 of the treaty, and of countries more broadly examining what lessons from this experience may be relevant when addressing industry interference related to other health-harming products.



Key insight

Left unchecked, health-harming industries not only ‘interfere’ with health policy—they shape it. Durable progress depends on governance that insulates policymaking from capture. That includes legal mandates and codes of conduct, limits and transparency on interactions, prohibitions on partnerships and corporate social responsibility activities where conflicts of interest are irreconcilable, and empowered civil society to counter industry narratives.

Evidence drives reform when it is locally owned

The ICAs showed that locally generated and nationally validated evidence was central to the credibility and usefulness of investment cases. By quantifying economic losses and modelling returns on investment, the analyses resonated with ministries of finance, planning, and labour, helping to secure their participation in both technical discussions and broader policy and political decision-making processes. Wherever possible, the investment case work drew on national data, validated across sectors, and was supplemented with agreed proxy data only when necessary. This approach was important in building buy-in, with the co-production process strengthening legitimacy and helping ensure that findings were understood and taken seriously.

Credibility depends on national relevance. The ICAs found that when analytical assumptions were adapted to reflect country realities, the analysis resonated more strongly. In Thailand, for example, labour-productivity estimates were adjusted to account for both formal and informal employment patterns. In contrast, in Peru, productivity assumptions drawn from higher-income contexts made the findings feel less grounded.

Data availability was a major determinant of credibility. Gaps in national datasets, such as an

absence of NCD risk factor prevalence and epidemiological information, from a lack of updated WHO STEPwise Approach to NCD Risk Factor Surveillance (STEPS) surveys, or reliance on aggregated rather than disaggregated health accounts, limited the precision of some analyses. In some countries, these constraints made it difficult to fully anchor reform arguments in robust national evidence.

However, imperfect data, provided there is national ownership for the approach being used, can still drive reform. Many governments used investment cases as advocacy tools even when some estimates were approximate. The process itself often acted as a mirror, revealing weaknesses in surveillance, costing, and health accounts, and highlighting where systems require sustained investment. Tobacco control investment cases illustrated this potential: in Serbia, the analysis recommended strengthening institutional capacity for enforcement, while in Sri Lanka, the investment case informed the incorporation of tobacco control indicators into the Monitoring and Evaluation Indicators for Prevention and Control of Cancers in Sri Lanka 2020–2024 framework, reinforcing accountability for implementation.



Key insight

Evidence drives action when it is developed and owned by the stakeholders who will use it. When data and analysis are locally grounded, co-produced, politically salient, and timely, they are more likely to shape present and future decisions.

Shocks reshape political windows for action

Investment cases show that crises can catalyze bolder action by disrupting policy hierarchies and creating openings to link NCDs and related risks with broader agendas. This was evident during the COVID-19 pandemic: in Suriname, the National Preparedness and Response Plan incorporated NCDs and mental health, and UN partners recommended using this momentum to integrate these priorities into the wider response.

However, in almost all countries the pandemic also diverted attention and disrupted essential services, delaying diagnoses, interrupting treatment, and worsening outcomes for people living with NCDs, who faced higher risks of severe COVID-19.

Gains endure only when urgency is used to embed prevention and resilience goals into mandates,

budgets, and monitoring systems. Conversely, zero-sum framings that pit emergency response against long-term prevention undermine both. This reinforces the need to integrate NCDs and mental health into global health security and UHC.



Key insight

Crises may open windows, but they rarely keep them open. Lasting progress depends on converting urgency into governance and budgetary reforms that anchor prevention and resilience long after the crisis fades.

Culture and context shape what is feasible and how progress is achieved

The ICAs showed the influence of social and cultural contexts in shaping the feasibility of reform and informing strategies that resonate.

Cultural norms can complicate prevention. In Zambia, stigma around exercise limited uptake of health promotion initiatives. In Türkiye, sociocultural norms contribute to significantly lower levels of physical activity among women, whose average daily duration of physical activity is approximately three times lower than that of men. In Jamaica, norms around food, body image, and masculinity shaped health behaviours. Examples include positive perceptions of larger body size among women and traditional ideals of toughness among men.

Structural barriers constrain options. In Qatar, high temperatures and limited infrastructure for heat-resilient mobility restrict opportunities for outdoor physical activity. In Mongolia, traditional high-salt diets, combined with limited access to fresh produce, particularly in rural areas, pose challenges for dietary reform and salt-reduction efforts. In Suriname, the concentration of mental health services in a single national hospital limited equitable access to care, underscoring the need for decentralization and stronger community-based approaches. Similar patterns appeared across other mental health ICAs, where poverty, violence, stigma, and displacement both drive distress and constrain access to care.

Governments are tailoring approaches for impact. In Saudi Arabia, physical activity has been framed in public campaigns as a patriotic duty, aligning health and wellness with national pride and collective responsibility. In Jamaica, the government's Jamaica Moves campaign used music-driven outreach and public ambassadors to broaden engagement, while its Big Man Ting campaign reframed masculinity as a source of pride in taking charge of one's health.

In Mongolia, major private food producers voluntarily reduced salt content following Ministry of Health engagement, including a company producing roughly half the nation's bread. In Qatar, women's sports associations participated in national health strategy planning, and schools were engaged through the Qatar Active Schools programme and anti-smoking initiatives.



Key insight

Cultural norms and structural conditions rarely appear in economic models but ICAs help determine what is politically and practically feasible, and how recommendations should be tailored. Progress succeeds when strategies are framed in locally resonant terms, anchored in trusted institutions, and advanced strategically.

Civil society underpins implementation and accountability when given space to operate

The ICAs revealed wide variation in civil society engagement. In many countries, civic actors were absent, marginalized, or focused narrowly on treatment and care. This left primary prevention and broader determinants with limited visibility and reduced the pressure on governments to act. But where civil society coalitions were stronger, advocacy, media, and legal action proved catalytic, helping push reforms onto crowded political agendas.

Civil society drives implementation, advocacy, and public support. In Georgia, the Tobacco Control Alliance, a coalition of 15 NGOs, has been a powerful partner in advancing tobacco control, issuing policy statements, engaging with legislators, and supporting enforcement. In Lebanon, civic and academic groups led media and outreach campaigns that built strong public backing for tobacco-control legislation; organizations such as the Tobacco Free Initiative collaborated with authorities to help enforce bans through the Tobacco Control Citizen Watch. In Ghana, Vision for Alternative Development played a crucial role in supporting passage of the Excise Duty Amendment Act 2023 (Act 1108) despite strong industry pushback, working alongside other CSOs, research institutions, UN agencies and other development partners.

Civil society's role in mental health reform also varies. In Kenya, civic groups have worked with county governments, notably in Makueni, to destigmatize mental health and expand services. Advocacy by the First Lady and digital initiatives has further shifted public attitudes, though stigma and uneven decentralization remain significant challenges. In Zimbabwe, reports highlighted persistent stigmatization and legal barriers but made little reference to civil society engagement beyond recommendations for future involvement, suggesting that civic participation in mental health remains limited or under-documented.

The ICAs also highlighted the importance of ensuring that those most affected by structural risks have a voice in decision-making. Across the air pollution investment cases (Gurugram and Amritsar in India; Ethiopia; and Mongolia), women and rural households reliant on solid fuels were identified as among the most affected. This underscores the importance of ensuring their perspectives are represented in policy and planning processes, as effective air pollution mitigation depends on understanding household energy practices, exposure pathways, and local implementation constraints.

Formal inclusion strengthens accountability. In Barbados, the National Chronic Non-Communicable Diseases Commission institutionalizes civil society representation, including NGOs, faith-based groups, trade unions, academia, and people living with NCDs. In Thailand, the Thai Health Promotion Foundation provides standing channels to engage and fund civil society and includes independent non-government experts on its multisectoral board, ensuring regular avenues for input and public participation. In the Philippines, coalitions of health, professional, and civil society organizations played a central role in advancing tobacco taxation and contributed to advocacy around UHC.



Key insight

Civil society is not an optional partner but a requirement for effective health governance. It provides voice, accountability, and legitimacy. Without it, the socio-economic case for health can lose visibility and political traction, government commitments can fade, and industry voices can dominate. With it, governments have stronger incentives to act, and reforms are more durable, with support for changes in policies from the community.

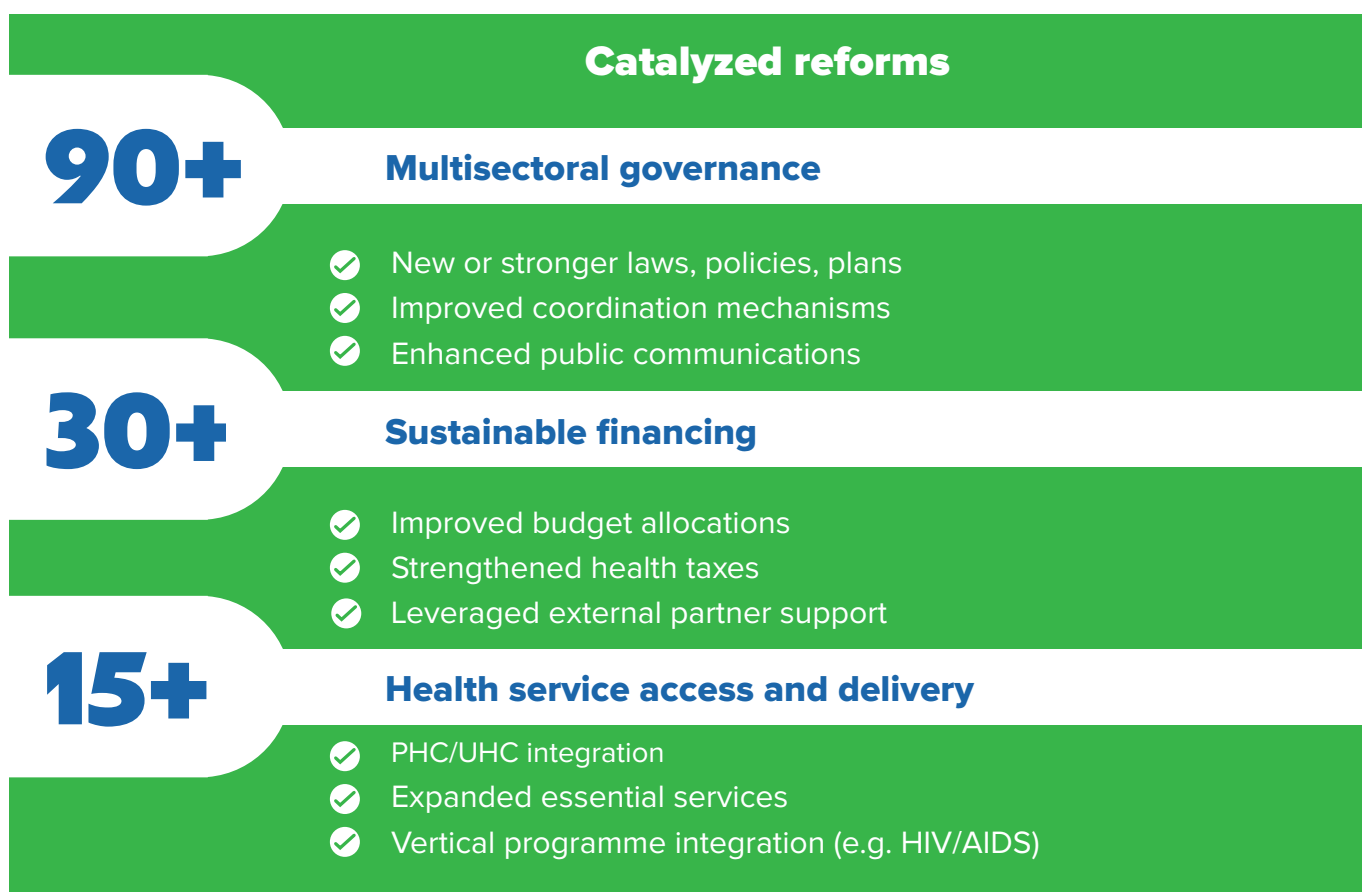
4



Impact

How investment cases
catalyze action

With national investment cases now completed across more than 60 countries, the key question is: what have they achieved? Evidence shows they have catalyzed significant reforms, though unsurprisingly no country has fully implemented all recommendations. Across countries, reported impacts and follow-on actions cluster around three domains – multisectoral governance, sustainable financing, health service access and delivery.



Evidence on these impacts draws on two complementary assessments. A 2024 British Medical Journal (BMJ) Global Health publication co-led by governments and UN partners identified 47 policy and system advances across 13 countries that had completed national NCD investment cases between 2015 and 2020. Building on this evidence, a 2025 survey undertaken by UNDP and the secretariats of the UNIATF and WHO FCTC collected 56 responses from stakeholders across 36 countries with investment cases for NCDs, tobacco control, and/or mental health, including inputs from ministries of health, UN agencies, civil society and academia. Together, the two assessments captured evidence on investment case use and follow-up across 38 countries.^{29,30}

29 Armenia, Bahrain, Barbados, Bhutan, Burkina Faso, Cabo Verde, Cambodia, Colombia, El Salvador, Ethiopia, Fiji, Georgia, Ghana, Iran, Jamaica, Jordan, Kazakhstan, Kuwait, Kyrgyzstan, Lao PDR, Lebanon, Mongolia, Mozambique, Nepal, Oman, Panama, Philippines, Russian Federation, Saudi Arabia, Sierra Leone, Sri Lanka, Tanzania, Thailand, The Gambia, Türkiye, Uganda, Uzbekistan and Zambia.

30 Findings synthesize evidence from Troisi et al. (BMJ Global Health, 2024. Available at: <https://pubmed.ncbi.nlm.nih.gov/38599663/>) and the 2025 UN partners survey, which were conducted independently using different methodologies.

Many reported reforms align with WHO-recommended “best buys”, the WHO FCTC, the WHO Mental Health Gap Action Programme (mhGAP), and other interventions needed to fast-track progress, and many have historically been challenging to achieve.

Box 6. Attribution versus contribution: understanding the role of the investment case

Often, no single activity can be identified as *the* reason a reform happened, reflecting the interaction of political, institutional, and economic factors over time, alongside the contributions of multiple partners. In the 2024 BMJ Global Health publication, countries were therefore asked to report only those impacts they believed were directly attributable to their investment case.

The 2025 survey went a step further, asking respondents explicitly: *What role did the investment case play in any reforms you reported?* Responses revealed a spectrum of influence:

- **18%** of responses described the investment case as a **major catalyst**;
- **54%** said it **accelerated reforms** already underway;
- **14%** viewed it as a **facilitating tool** that supported decision-making.

Among countries that enacted reforms, not a single one reported no influence from their investment case.

The ROI of showing ROI

Each investment case costs roughly US\$100,000 in direct expenditure, supplemented by staff time from governments and UN partners. Yet these analyses have unlocked lifesaving and systems strengthening reforms worth many multiples of that, in areas where progress had long been stalled. As such, the catalytic effect of the investment case activity itself has its own considerable ROI.



Selected examples of country-reported measures illustrate the type and range of actions adopted or implemented in contexts where national investment cases were developed, during or after that process.

This section categorizes these across multisectoral governance, sustainable financing, and health service access and delivery. In reality, many actions strengthen multiple of these domains at once, demonstrating how investment cases can catalyze systems change alongside broader efforts of governments and partners.³¹

Multisectoral governance

Laws, regulations and product standards

- Armenia, Cabo Verde, Fiji, Georgia, Kyrgyzstan, the Russian Federation, and Sierra Leone adopted tobacco control laws.
- Sri Lanka amended its National Authority on Tobacco and Alcohol Act and successfully defended the law in a legal case against the tobacco industry in 2025.
- Kyrgyzstan introduced municipal smoke-free policies;
- Cambodia endorsed standard operating procedures for smoke-free environments in tourism; and
- Colombia issued smoke-free signage requirements.
- Kazakhstan increased the legal age for tobacco purchase to 21;
- El Salvador updated tobacco health warning requirements;
- Lao PDR introduced tobacco plain packaging; and
- Panama advanced legislation on plain packaging.
- The Philippines eliminated industrially produced trans fats; and
- Saudi Arabia adopted nutrition- and diet-related regulations, including mandatory labeling of high-salt meals in restaurants and cafés.
- Ethiopia banned alcohol advertising.

Plans, policies, and strategies

- Cambodia, Ethiopia, Georgia, Thailand, Uganda, and Zambia developed national multisectoral NCD plans.
- Saudi Arabia integrated NCDs into its national development strategy.
- Georgia developed a Tobacco Control Strategy and Action Plan and initiated development of national policies on salt reduction and physical activity.
- The Gambia developed a national mental health policy and initiated a new mental health bill to replace outdated legislation.
- Jamaica advanced an updated mental health policy and strategic plan.

³¹ For example, the tobacco control investment cases delivered through the FCTC 2030 project were combined with broader support to accelerate treaty implementation, including sustained engagement by the Convention Secretariat, WHO, UNDP, and experts from civil society and academic organizations.

Coordination mechanisms

- Ethiopia, Jamaica, Kuwait, Thailand, and Uganda established or strengthened national multisectoral NCD committees.
- Uzbekistan enacted a Presidential Decree reorganizing the Ministry of Health, launching a healthy lifestyle center, and creating an intersectoral commission.
- Burkina Faso and Lebanon strengthened multisectoral tobacco control coordination; Burkina Faso also established a tobacco control authority.
- Jordan reactivated a high-level committee to coordinate follow-up on mental health recommendations.

Public communication

- Ethiopia and Türkiye implemented national salt reduction campaigns.
- Kyrgyzstan promoted smoke-free environments through public communication initiatives.
- Jamaica launched national campaigns on physical activity and nutrition.
- Iran implemented a national tobacco-free generation campaign.

Sustainable financing

Budgets and fiscal allocations

- Barbados established a dedicated NCD budget line and appointed a Minister for NCDs.
- Armenia and Jamaica increased budget allocations for NCD prevention and control; Jamaica also secured US\$100 million in loans from the Inter-American Development Bank for health system strengthening with a strong NCD focus.
- Ethiopia increased the share of total health expenditure allocated to NCDs, and Georgia increased funding for tobacco control.
- Jordan advanced discussions to secure resources for mental health services at PHC level.

Tax and price measures

- Ethiopia, Fiji, Ghana, Kazakhstan, the Philippines, Sierra Leone, and Sri Lanka increased tobacco taxes.
- Ethiopia and the Philippines reformed alcohol taxes, with the Philippines earmarking new revenues for UHC.
- Barbados introduced a sugar-sweetened beverage tax and later raised it; Ghana increased excise taxes on tobacco, alcohol, and sugary drinks.
- Saudi Arabia doubled the retail price of tobacco in hospitality venues through new sectoral fees.

Health service access and delivery

Service integration and system strengthening

- Barbados implemented cardiovascular risk reduction initiatives and strengthened community health worker capacity.
- Türkiye increased primary care funding for NCD service packages.
- Uganda integrated NCD services into HIV platforms, securing US\$4.5 million from PEPFAR.
- Jamaica included a focus on NCD prevention and control in a health systems strengthening programme.
- Oman developed a national risk chart for NCDs and scaled up nutrition-related interventions.
- Saudi Arabia adopted new clinical preventive guidelines and strengthened tracking of NCD risk factors, disease prevalence, insurance coverage, and OOP costs.
- Uzbekistan enacted a Presidential Decree extending mental health reforms, including vertical management of psychiatric and addiction care, integration with PHC, full provision of medicines, upgraded training and incentives, and strengthened school-based mental health programmes.

Box 7. How countries view and use investment cases

Visibility and prioritization

- » 82% said investment cases raised awareness among policymakers and stakeholders; only 2% disagreed.³²
- » 70% agreed investment cases elevated their subject within health, while 11% disagreed.
- » 52% agreed investment cases raised priority across other sectors, while 17% disagreed.

Technical and advocacy role

- » 59% agreed investment cases were a crucial tool for advancing the national response; 13% disagreed.
- » 86% said that investment cases were used in reports, making this the most common use. Campaigns were second at 84%, followed by presentations (82%), speeches (80%), media (71%), and policy briefs (70%). They also shaped planning (64%), legislation and policy (64%) and informed budgets (27%) and fiscal decisions (18%). Their use in policy dialogues remained rarer (4%).

Budgeting and financing

- » 34% agreed investment cases influenced sustainable budgeting and financing, 48% were neutral, and 18% disagreed.

What countries value most

- » Clear policy recommendations (77%).
- » Country-specific data and modelling (71%).
- » Economic framing of health in fiscal terms (66%).
- » Advocacy and communication tools (50%).
- » Multisectoral engagement opportunities (50%).
- » Explicit SDG linkages (34%).

Drivers of future investment cases

Countries identified changes in the national landscape that could inform new investment case development. These included legislative changes (59%), updated NCD policies (57%), increased cross-sectoral collaboration (54%), and updated budgets (48%). Far fewer pointed to changes in governance or institutional arrangements (32%), shifts in donor financing (25%), political leadership (23%), or macroeconomic trends (14%).

³² Responses based on the 2025 survey. Respondents were asked to rate their agreement to statements on a scale from 1 to 5, 1 being strongly disagree and 5 being strongly agree. It was interpreted that a response of 4 or 5 meant the respondent agreed, a response of 1 or 2 meant they disagreed and a response of 3 meant they neither agreed nor disagreed.

Box 8. Country voices: governments describe how investment cases make a difference

Armenia: “Staggering results from the economic analysis made the Government, and especially the Ministry of Finance, consider health as an investment, not a cost.”

Barbados: “The investment case has helped to promote the idea that allocating resources to NCD prevention and control is an investment rather than cost.”

Ethiopia: “Findings from the investment case supported collaboration between Ministries of Health and Finance around the taxation on health-harming products, that is, tobacco and alcohol. It was also used to support the ban on alcohol advertisement.”

Russian Federation: “The investment case provided the Ministry of Health and the Ministry of Finance with common vocabulary.”

Jamaica: “Data around the NCD burden, specific to the national context rather than aggregated regional or global data, were picked up very quickly ... to guide prioritization of funding towards national health system strengthening programmes particularly focused on the control of NCDs.”

Uzbekistan: “The NCD investment case was a real eye-opener for the Government; economic data convinced ministries other than health that it was necessary to tackle NCDs.”

5

Recommendations

Scaling and sustaining reform
through investment cases

The past decade has shown the catalytic power of investment cases. However, progress must not be mistaken for success. Implementation remains partial, uneven, and far too slow to achieve the NCD- and mental health-related targets in both the SDGs and the 2025 Political Declaration on NCDs, Mental Health, and Well-being. To bridge the gap between evidence and sustained, system wide action, this section outlines a strategic set of recommendations for the accelerated implementation of national investment case recommendations. It is structured around three, mutually reinforcing priority areas: institutionalization and governance; financing and fiscal sustainability; and partnerships and collective action. This framework is grounded in country insights and forward-looking strategies to ensure impact at scale by 2030 and beyond.

Institutionalization and governance

A. Planning, frameworks and budgets

Embed investment case evidence and recommendations directly into plans, frameworks, and budgets.

- ➔ **Move from strategies to costed, prioritized plans.** Turn broad health strategies into costed, prioritized plans with SMART objectives³³ and clear roles, responsibilities, and budgets.
- ➔ **Embed priorities in national development frameworks.** Anchor priorities in national health strategies, UHC roadmaps, SDG strategies, and broader sectoral plans.
- ➔ **Strengthen priorities in budget processes.** Use ROI and cost-of-inaction evidence to link cost-effective actions to budget circulars and Medium-Term Expenditure Frameworks.



Photo: © UNDP

33 Smart, Measurable, Achievable, Relevant and Time-bound.

Country insights on implementation



Bhutan: “Investment cases provide an evidence-based rationale for urgent actions and resource allocation and serve as a key reference for budget planning and monitoring progress.”

The Philippines: “For countries with limited budget, the investment case can help shape and narrow down key interventions with potential impact and ROI.”

B. Coordination and service delivery

Use investment case findings to equip coordination platforms and PHC reforms with the authority, resources, and multisectoral reach required for effective implementation.

- ***Strengthen whole-of-government and whole-of-society platforms.*** Highlight co-benefits across development agendas, creating shared stakes beyond health. Ensure inclusive platforms to broaden legitimacy, as well as transparency, conflict-of-interest rules, and accountability to protect policy space from capture.
- ***Embed priority services into PHC.*** Integrate NCD and mental health services into PHC and link them with multisectoral action (e.g. across education, food, and social protection).

C. Accountability and adaptation

Embed investment cases in monitoring and policy processes and evolve them with new evidence, political shifts, and fiscal realities.

- ***Establish continuous and systematic data collection.*** Use routine reporting systems to ensure regular, reliable collection of the indicators needed to track implementation and refresh analyses over time, leveraging digital innovations.
- ***Strengthen accountability mechanisms.*** Use investment case benchmarks in dashboards, reporting and data-return platforms, information systems, budget reviews, and parliamentary oversight.
- ***Build national analytic capacity.*** Equip domestic teams to refresh analyses with updated data and policy baselines, conduct deeper assessments (e.g. on trade, jobs, revenue, gender and equity dimensions), maintain monitoring systems, and respond to country demand for shorter-term, budget-aligned reform planning. Utilize light update modules and global tools, including digital and AI-assisted modelling, to support this work where this would reinforce country-led processes.



Country insights on implementation

Colombia: “The investment case can be used at any time...but it needs to be updated to maintain its impact.”

Jamaica: “[There is a need to] update the 2017 report with post-COVID data and the latest WHO best buys to strengthen relevance.”

Panama: “Regular updates are needed to keep findings relevant.”



Photo: © UNDP

D. Whole-of-government leadership

Engage finance ministries, parliaments, and coordination platforms from the outset of the investment case process, with clear institutional mandates and accountability.

- **Engage finance and economy ministries as full partners.** Build on the existing inclusive process by involving these sectors even earlier (including in design) and exploring a shift from ministry of health-led cases to fully cross-government, co-owned analyses.
- **Elevate coordination politically and locally.** Place investment case priorities under cabinet or prime-ministerial leadership to give them cross-government authority, while involving local authorities and communities to support implementation of priority actions and maintain alignment between national and subnational levels.

Country insights on implementation

Lebanon: “The investment case should provide a baseline to track policy effectiveness over time.”

Bahrain and Mozambique: “Monitoring and evaluation must be embedded in national coordination mechanisms to reinforce accountability.”

Tanzania: “Track financial and socio-economic impact.”

Georgia: “Investment cases should better address the detailed questions of finance and economic sectors to strengthen engagement and implementation.”

Ethiopia: “Prioritize best buys in phases (immediate [3 years], mid-term [5-8 years], long-term [after 8 years]) to make implementation feasible.”

Uzbekistan: “[National investment cases] should be used as a model for smaller projects on the local level.”



Financing and fiscal sustainability

A. Health system financing

Integrate NCD and mental health services into UHC benefit packages with secure financing, using investment cases to provide the country-specific evidence to expand coverage, fund priority services, strengthen PHC delivery, and reduce household financial risk.

- **Make the case for inclusion.** Argue for adding priority NCD and mental health services to UHC benefit packages. Ground reforms in equity, addressing disproportionate burdens on low-income and other vulnerable groups.
- **Back inclusion with financing.** Translate inclusion into funded commitments by securing budget lines and integrating costed priorities into annual and medium-term expenditure frameworks. Use investment case evidence to demonstrate value for money and strengthen the case for sustained financing.
- **Protect households.** Draw on investment case analysis of OOP spending and productivity losses to design stronger financial protection so families are not driven into poverty by preventable conditions. Ensure coverage mechanisms prioritize groups at greatest financial risk.

B. Macro-fiscal architecture

Embed investment case findings across fiscal and financing systems, extending beyond health budgets into broader macro-fiscal architecture.

- **Inform macro-fiscal strategy.** Use evidence on the costs of inaction, alongside the medium- and long-term savings from earlier, cost-effective responses, to position health as a strategy for reducing fiscal risk and strengthening productivity within debt sustainability, economic growth, and workforce development agendas. Apply these insights in fiscal space analyses, expenditure reviews, budget tagging, and programme-based budgeting so the economic value of prevention and priority health actions is fully reflected in fiscal allocations.
- **Apply a fiscal policy coherence lens.** Assess whether revenue, expenditure, and debt policies pull in the same direction towards NCD and mental health outcomes. Identify and address any misalignments, such as tax exemptions, subsidies, or pricing policies that may exacerbate NCD and mental health challenges.
- **Embed findings in national financing frameworks.** Integrate NCD and mental health priorities into Integrated National Financing Frameworks (INFFs) and related national financing strategies, ensuring that implementation financing is mobilized and aligned across all sources: public budgets, domestic revenue, external partners, and private investment.

→ **Coordinate investment cases as a portfolio.** As investment cases multiply across issues, governments should treat them as a connected portfolio rather than isolated reports—capturing synergies, reducing overlaps, and avoiding zero-sum competition for fiscal space. This coherence requires modelling of co-benefits within health and across sectors, stronger national analytic capacity, and coordinated partner support.

C. Domestic revenue mobilization

Use investment case evidence to make the social, economic, fiscal and equity case for stronger health taxes, including to address budget strains, reduced external aid, and sustainability and co-financing expectations associated with major global health initiatives.

→ **Strengthen health taxes.** Pair investment case evidence on the ROIs of health taxes with dedicated analyses on fiscal impacts and support for ministries of finance and revenue authorities to design optimal tax structures and strengthen administration.

→ **Channel revenues visibly.** Link new or increased revenues to public priorities, such as affordable healthcare, housing and education, to build trust and reduce political risk. Use ICAs to shed light on which linkages are most likely to garner public support.



Photo: © World Bank

Box 9. Health taxes: high returns and growing momentum

A report from the Task Force on Fiscal Policy for Health finds that raising tobacco, alcohol, and sugary drink prices by 50 percent through excise taxes could generate US\$3.7 trillion over five years, including US\$2.1 trillion in LMICs—enough to boost government health spending in these countries by 40 percent.³⁴

UNDP's policy brief, *Empowering Women Through Health Taxes*, shows that health taxes also reduce inequitable burdens on women and girls, from secondhand smoke and alcohol-linked violence to caregiving and household costs, while generating revenue that can be reinvested in gender equality.³⁵

Global commitments reinforce the case: the 2015 Addis Ababa Action Agenda and the 2025 Sevilla Commitment position health taxes as development finance solutions, while the 2025 Political Declaration on NCDs, Mental Health, and Well-being calls for countries to consider introducing or increasing such taxes to advance health objectives.

The WHO-led “3 by 35” initiative provides a platform for countries to access coherent, aligned support as they pursue the goal of raising the real prices of tobacco, alcohol and/or sugary drink products by at least 50 percent by 2035, helping translate global political momentum into nationally led fiscal reform.³⁶

D. Catalytic aid and external financing

Use investment cases as credible, country-owned reform roadmaps to attract, align, and coordinate external financing in support of priority reforms.

➔ **Engage development banks and international financial institutions.** Use investment cases to translate NCD and mental health priorities into investment-ready portfolios of cost-effective interventions that can be integrated into policy-based lending and financing operations. Convene multilateral and regional development banks around a shared national roadmap to sequence reforms and leverage concessional and blended financing.

34 The Task Force on Fiscal Policy for Health Report 2024. Health Taxes: A Compelling Policy for the Crises of Today. Available at: <https://assets.bbhub.io/dotorg/sites/64/2024/09/Health-Taxes-A-Compelling-Policy-for-the-Crises-of-Today.pdf>

35 UNDP, Policy brief: Empowering women through health taxes, 2025. Available at: <https://www.undp.org/asia-pacific/publications/policy-brief-empowering-women-through-health-taxes>

36 WHO, The “3 by 35” Initiative targets tobacco, alcohol, and sugary drinks to cut deaths and boost health and development funding, 2025. Available at: <https://www.who.int/news/item/02-07-2025-who-launches-bold-push-to-raise-health-taxes-and-save-millions-of-lives>

- **Align and diversify external support.** Use investment cases to align donors, vertical funds, development banks, and UN agencies behind a common set of nationally owned priorities to reduce fragmentation and mobilize a mix of grants, pooled funds, loans, and impact-linked or blended instruments. Where appropriate, use pooled financing mechanisms like the Health4Life Fund to support alignment.
- **Bridge transition risks.** Use investment case evidence to secure catalytic funding that covers upfront or transitional costs, such as the early roll-out of priority PHC services or initial administration of health tax excise reforms, enabling governments to sustain these reforms with domestic financing over time.

International Financing Dialogue on NCDs and Mental Health (2024)

The WHO–World Bank dialogue convened 150+ stakeholders ahead of the 2025 High-Level Meeting of the General Assembly on the Prevention and Control of NCDs and the Promotion of Mental Health and Well-being. Its priorities—aligning fiscal reforms, UHC financing, and catalytic funding with nationally led strategies—closely mirror the shifts emphasized by countries in the 2025 investment case survey, underscoring a consistent agenda for sustainable action.³⁵



37 WHO, International dialogue on sustainable financing for NCDs and mental health, 2024. Available at: <https://www.who.int/news-room/events/detail/2024/06/20/default-calendar/international-dialogue-on-sustainable-financing-for-ncds-and-mental-health>

Partnerships and collective action

A. Whole-of-society engagement

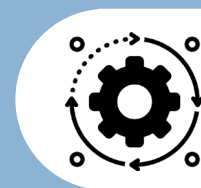
Use investment cases to actively build whole-of-society coalitions that translate evidence into legitimacy, support, and accountability across government and society.

- **Equip parliaments for legislation and oversight.** Use ROI and cost-of-inaction evidence to support parliamentary advocacy for reform, secure budgets, and strengthen oversight, including by reinforcing committee mandates and research services to institutionalize evidence-based decision-making.
- **Meaningfully engage civil society, communities, youth movements, and faith-based organizations.** Involve these actors early to shape priorities and use findings to anchor their participation in policy dialogues and coordination platforms—keeping reforms people-centered, equitable, and grounded in lived realities.
- **Partner with academia and think tanks.** Involve them in validating and adapting methods, filling evidence gaps and translating findings into policy. That includes capturing emerging evidence (e.g. the mental health effects of air pollution) and moving beyond averages to better understand dimensions of equity.
- **Work with media.** Generate compelling narratives that frame NCDs and mental health as public and political priorities, track commitments, and make upstream reforms tangible for citizens, for example how a tax finances treatment or how a law delivers clean air.
- **Engage the private sector, where appropriate, constructively.** Shape partnerships in areas such as product reformulation, insurance design, wellness services, and digital innovation, while applying strict safeguards to manage conflicts of interest and align with WHO guidance on health-harming industries.³⁸

38 WHO recommends no engagement with the tobacco industry, restricted interaction with the alcohol industry limited to regulation and control, and managed, transparent engagement with food, beverage, and other industries where reform may support public health.

Legislators turning evidence into action

The 2025 *Global Legislators Report on Noncommunicable Diseases and Mental Health Conditions: A Threat to Health and a Threat to Wealth*³⁷ strengthens parliamentary leadership on NCDs and mental health. Written by legislators for legislators, it was led by the G20 & G7 Health and Development Partnership with the Commonwealth Parliamentary Association and the Parliamentary Assembly of the Mediterranean, and developed with the UNIATF, including UNDP. The report includes a model resolution and comprehensive action toolkit. Combined with country-specific economic evidence from investment cases, these tools can accelerate legislative action.



B. International cooperation and learning

Use the body of investment case work to align international development partners behind nationally owned priorities, while responding equitably to country demand for additional cases and enabling learning and cooperation across contexts to scale impact.

- ***Align international support.*** Anchor the technical, policy and implementation support of donors, development banks, and the UN system in national priorities and evidence, reducing fragmentation in the spirit of UN80 reform. Coordination platforms such as the UNIATF can support this alignment by convening partners and reinforcing whole-of-system coherence.
- ***Meet demand equitably.*** Governments and partners should mobilize resources jointly to respond to growing country demand for investment cases, including refreshed analyses and expansion into new areas. Ninety-four percent of surveyed countries seek either an updated case or one in a new domain,⁴⁰ and others await their first.
- ***Strengthen South–South and triangular cooperation.*** Turn the growing body of evidence and experience from investment cases into actionable learning, helping countries to tailor approaches and accelerate reforms. Triangular cooperation can further enhance impact by mobilizing additional resources, technology, and innovation, while ensuring higher-income countries also benefit from solutions emerging in lower-resource contexts.

39 UNIATF, Global legislators report and model resolution on NCDs and mental health conditions launched during eightieth UN General Assembly, 2025. Available at: <https://uniatf.who.int/about-us/news/item/24-09-2025-global-legislators-report-and-model-resolution-on-ncds-and-mental-health-conditions-launched-during-eightieth-un-general-assembly>

40 Countries expressed demand for cases in NCDs, tobacco control, mental health, air pollution, digital health, road safety, nutrition, physical activity, and access to medicines.

Box 10. South–South and triangular cooperation for NCDs and mental health

South–South and triangular cooperation are not only vehicles for technical exchange; they are mechanisms for shared problem-solving and collective acceleration of reform.

The Health4Life Fund’s South–South Learning Lab was established in response to demand from Member States and strategic partners for a platform to accelerate knowledge sharing and innovation on NCDs and mental health. Its flagship convening during the 2025 UN General Assembly, *Scaling up Action on NCDs and Mental Health: A South–South Exchange on the Role of Investment Cases*, brought together Cameroon, Jamaica, Saudi Arabia and Thailand, alongside youth, funders, and civil society.⁴¹ It marked the first step in a longer-term effort to connect countries working at different stages of reform to exchange policy solutions, implementation experience and financing approaches.

Building on Decision FCTC/COP5(13),⁴² which formally recognized and encouraged South–South and triangular cooperation for implementation of the WHO FCTC, the FCTC 2030 Project⁴³ is supporting LMICs to strengthen legislation, implement fiscal and regulatory measures, promote policy coherence, and foster peer learning. With 36 national tobacco control investment cases completed, the FCTC 2030 Project offers a powerful vehicle for driving health and development progress through South–South and triangular cooperation.

UN Office for South-South Cooperation (UNOSSC) platforms such as South–South Galaxy⁴⁴ and the India–UN Development Partnership Fund⁴⁵ link countries with knowledge, financing, and implementation support across regions, creating additional avenues to advance NCD and mental health priorities.

41 UNOSCCC, UNDP Convenes Global Leaders to Scale Up Investment in NCDs and Mental Health, 2025. Available at: <https://southsouth-galaxy.org/news/undp-convenes-global-leaders-to-scale-up-investment-in-ncds-and-mental-health/>

42 Conference of the Parties to the WHO Framework Convention on Tobacco Control, Fifth session, Seoul, Republic of Korea, 12–17 November 2012. Available at: [https://apps.who.int/gb/fctc/PDF/cop5/FCTC_COP5\(13\)-en.pdf](https://apps.who.int/gb/fctc/PDF/cop5/FCTC_COP5(13)-en.pdf)

43 Secretariat of the WHO FCTC, FCTC 2030. Available at: <https://fctc.who.int/convention/development-assistance/fctc-2030>

44 UNOSCC, home page. Available at: <https://southsouth-galaxy.org>

45 UNOSCC, The India-UN Development Partnership Fund. Available at: <https://unsouthsouth.org/indiaunfund/>

6



Conclusion

Progress in addressing NCDs and mental health challenges remains off track in many countries. Overlapping crises, including conflict, economic instability, and climate change, are threatening health and health systems while tightening already constrained fiscal space. These pressures often fuel austerity at the precise moment when investment in health becomes most essential. Health is foundational to prosperity, well-being and sustainable development. Addressing NCDs and mental health is not a competing priority, but a core pathway for countries and communities to withstand and recover from shocks.

National investment cases have made this argument clearly across more than 60 countries worldwide. They have revealed the costs of inaction and demonstrated the returns available from evidence-based interventions. They have also surfaced the structural barriers that continue to impede progress, including commitments not backed by budgets or cross-sectoral mandates, industry interference in policymaking, and inadequate engagement of civil society.

Building on this clarity, investment cases have catalyzed concrete action on NCDs and mental health. Countries report impacts across three core domains: multisectoral governance, sustainable financing, and health service access and delivery. That includes new laws and policies, better coordination across sectors, increased budget allocations, greater use of health taxes, and the integration of NCDs and mental health into PHC and UHC. These measures demonstrate how nationally owned evidence can drive policy and systems change, and also that much more can and must be done.

The 2025 Political Declaration on NCDs, Mental Health, and Well-being is the most ambitious commitment to date on these issues. To deliver on its promise, a decisive shift is required from the foundation-setting and uneven, partial progress that has defined this agenda since 2011 toward a next era of deep, sustained implementation at scale. This paper, grounded in evidence and experience from countries worldwide, points to three decisive arenas of action: institutionalization and governance; financing and fiscal sustainability; and partnerships and collective action. Its strategic framework provides a practical basis for countries and partners to translate political commitment into more durable action on NCDs and mental health.

That countries must still “make the case” for scaled up action on the predominant drivers of early death, disease, and disability is in itself revealing. It reflects the chronic undervaluation of NCDs and mental health, resulting in decades of underinvestment, normalized loss, and the opportunity cost of a healthier, more equitable and more sustainable world. But it would also be inaccurate to paint the past decade as one of complete inaction. In an area of health facing major commercial counter pressures, and limited external aid, countries have been building up their responses brick-by-brick. The large and growing body of national investment cases, including the range and depth of partnerships that have underpinned these, now provides a strong foundation to collectively move faster and at greater scale from progress to transformation.



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