

Summary of technical background papers

Technical background papers have been developed by a team of staff from WHO, the World Bank and the University of Washington with the input of contracted consultants, as needed; all papers have benefited from the review and feedback of an External Technical Expert Group appointed to support the International dialogue on sustainable financing for NCDs and mental health. The papers will undergo further review by WHO and the World Bank; therefore, they do not represent the official positions of both organizations. The papers are the property of WHO and the World Bank. They may only be downloaded for the purpose of this web consultation and their content cannot be used for any other purpose.

Background

Over the past two decades, noncommunicable diseases (NCDs) and mental health have gone from niche topics in global health to central parts of the sustainable development agenda. There has been a massive increase in scientific evidence on disease burden, cost-effective intervention options, and country experiences with implementing disease programmes. Since the 2011 High-level Meeting on the Prevention and Control of NCDs, the amount of development assistance allocated to these conditions—while modest—has doubled. Politicians in low- and middle-income countries are regularly talking about these conditions. Though more could have been done, considerable progress has been made.

Still, we live in challenging times. The macro-fiscal outlook is unfavourable in many countries, with slow growth, inflation, and debt burdens pressuring public budgets. Progress towards Universal Health Coverage has been slow, with some countries seeing increases in out-of-pocket spending on health, and service coverage falling short of aspiration in most countries. Geopolitical tension and outright conflict are on the rise, distracting countries from implementing their health policy agendas. The global community is struggling to act on climate change. The list goes on. Thus, the challenge for NCDs and mental health is: “do more with less”.

Against this backdrop, WHO and World Bank are convening an International dialogue on sustainable financing for NCDs and mental health. This dialogue will revisit the recommendations of the 2018 Global Dialogue on Partnerships for Sustainable Financing of

NCD Prevention and Control, considering the changed world we live in. It will identify policy options and strategic approaches that enable and enhance the integration of high-value NCDs and mental health interventions into national health and financing systems.

A number of technical papers that address various dimensions of NCD and mental health financing have been prepared for the international financing dialogue. The evidence in these papers comes from several sources:

- review of previous WHO and World Bank guidance
- structured literature reviews
- desk reviews of national policies on NCD and mental health
- interviews with key informants in government, civil society, and the donor community
- quantitative analyses.

The papers were developed over the past several months by WHO and World Bank staff and consultants. They were then reviewed by an External Technical Expert Group comprised of 17 international experts in financing and NCDs and mental health.

Paper 1: Health expenditures on NCDs and mental health: What can health accounts tell us?

Conversations about financing NCDs and mental health must start with an assessment of current spending. This paper looks at data from national health accounts (NHAs) in 59 countries over the period 2013–2021, emphasizing subaccounts on NCD and mental health programmes. Most of the countries in the dataset are low- or lower-middle-income countries.

The data show that spending varies a lot, and spending on NCDs and mental health, as a share of total health spending, is positively correlated with national income. For example, within the Africa Region, the Democratic Republic of the Congo spent around US\$ 2 per capita during 2016–2019, whereas Gabon spent around US\$ 80–90 per capita during 2015–2019. Higher-income countries are spending even more: North Macedonia, for instance, spent US\$ 300 per capita in 2021.

A big part of the story on NCD and mental health spending is the high share of out-of-pocket (OOP) spending. In the African Region, OOP spending accounted for 74% of total spending on NCD and mental health. This is considerably higher than OOP spending on health in general (which averaged 40% across all programmes in these countries). The data also show

differences within NCD and mental health. Cardiovascular diseases accounts for a plurality of spending, whereas mental health ranges from 10% to 38% of total NCD and mental health spending. The share of spending on mental health is also positively correlated with national income.

It is challenging to generalize these findings to the world. Most countries are not contributing NHA data to WHO. Even among those that are, there are big differences in the quality and accuracy of the data, especially at the disease-specific level. An implication of this analysis is that WHO, other international organizations, and ministries of health need more resources to allow them to support expenditure tracking. How to best use newer sources of data, such as health insurance claims, is an area for future research.

Paper 2: The role of development assistance in NCD and mental health finance

While most financing for NCDs and mental health comes from national governments, there is an important role for development assistance to support country efforts. Paper 2 covers this topic and provides recommendations for current and prospective donors.

We conducted a desk review of development projects and did key informant interviews with a range of stakeholders in international organizations, civil society, and the private sector. We found that there is a lot happening “on the ground” with development assistance for NCDs and mental health, but much of it is happening through general support for primary health care. Increasing international resources for NCDs and mental health will require this community to grapple with several thorny “agenda-setting” problems that have persisted for years. Still, the surge in interest in these conditions is a promising sign.

We provide specific guidance on so-called “catalytic” funding for NCDs and mental health at the national level. These projects are intended to jumpstart local programmes and attract further investment and eventually be handed over to national governments. We give examples of successful catalytic projects and recommendations for areas that are especially suited to this type of investment, as well as areas for caution. We also propose several cross-cutting external investments that can strengthen NCD and mental health programmes even though they are not disease specific; these include capacity-strengthening in economic evaluation and digitalization of health information systems.

A complementary role for development assistance for NCDs and mental health is in financing “collective action” at the regional and international level and supporting the development of

public goods. Again, there are several successful examples highlighted in the paper. We conclude the paper with some reflections on high-priority opportunities for public goods that would be produced at the regional level. Financial support is also needed to coordinate many projects and facilitate cross-country learning and exchange of best practices.

Paper 3: The role of fiscal measures in addressing NCDs and mental health

The ministry of finance is not only a source of money for health. It is a partner in implementation of some of the most effective public health interventions for NCDs and mental health. Paper 3 explores the role of fiscal measures to prevent NCDs and improve mental health.

Most of the paper is devoted to health taxes, with a strong emphasis on tobacco excise taxes. Tobacco, alcohol, and sugar-sweetened beverage taxes are all highly effective but are not being implemented as well as they could. The paper summarizes the challenges that countries face in health tax implementation and cites recent guidance from WHO on the optimal design of these taxes. Health taxes are also a significant source of government revenue in many countries and hiking them to WHO-recommended levels could increase revenues even more. However, the health impact of these taxes is a sufficient justification. Contrary to industry claims, there is no evidence that they are bad for economic growth or adversely affect the poor.

The paper also delves into an emerging topic: subsidies on products that harm health. Two categories of subsidies are especially problematic, fossil fuel subsidies and agricultural subsidies. Removing these subsidies would improve NCD and mental health outcomes and free up government resources for other sectors. Subsidy removal is politically difficult and needs to be accompanied by social safety net measures to ensure the poor are not adversely affected.

Public health experts frequently advocate for health tax revenues to be earmarked to the health budget as a means of increasing resources for the health sector (and sometimes for NCD and mental health programmes). The paper summarizes the pros and cons of earmarking and generally urges caution on the matter. Still, some countries have managed to get more resources for health through earmarked funds, although they have generally been small as a share of the total health budget.

Paper 4: Improving domestic financing for NCD and mental health care

The biggest question in NCD and mental health finance is the role of domestic financing systems in resourcing service delivery for these conditions. Paper 4 tackles this issue, starting with an acknowledgement that there is one health financing system, and it is not disease specific. Several general health financing reforms, such as improved public financial management, will likely yield major gains in resources for NCDs and mental health. However, these are part of the overall health and UHC agenda and are not the primary responsibility of NCD and mental health experts.

We present a framework for identifying opportunities for specific finance of NCD and mental health activities. Health promotion and prevention (e.g. mass media campaigns), and disease-specific programmes to enhance intervention implementation (e.g. population-based screening) can be entry points for targeted investment apart from entitlement spending.

The paper reviews the experiences of several countries in financing NCDs and mental health. An emerging conclusion of this exercise is the role of multisectoral coalitions in advocacy for resource mobilization and accountability for action. The case studies also show the breakdown between political commitment to NCDs and mental health (which most countries have shown) and financial commitment. We propose a series of steps to improve financial commitment through disease-informed health benefits package revisions and provider payment reforms.

The future success of NCD and mental health financing will depend on greater investment in modern, digital health information systems that are able to effectively (i) track expenditures transparently, (ii) coordinate and integrate financing across episodes of care for persons with chronic diseases, and (iii) assist ministries in budgeting for future rather than current demand. Need for long-term care is an emerging topic with great potential for cross-country learning.

Paper 5: Financial protection for NCDs and mental health: why and how?

Paper 1 highlighted that the predominant source of spending on NCDs and mental health is OOP. Paper 5 takes a step further and explores OOP spending—as an indicator of inadequate financial protection—with a focus on medicines as a driver of OOP spending.

Conversations about financial protection typically revolve around prepayment to protect against infrequent, high-cost services like hospitalizations and surgeries. Yet individuals and households affected by NCDs and mental health conditions face heightened financial risks due to lengthy (or lifelong) duration of care. Because of their chronic health conditions, their opportunities to generate income are less. The evidence suggests that the “slow burn” of lower-cost, higher-frequency healthcare over a long period is a critical driver of OOP spending and financial hardship related to NCDs and mental health.

The paper shows how spending on medicines is a major contributor to this slow burn. Perhaps surprisingly, OOP spending on medicines is high, even in countries with, e.g. “free care” policies or social health insurance systems. The main reason seems to be poor policy implementation. Taking the previous two examples, stockouts of medicines at public-sector pharmacies, and high copayments for medicines (in part from insufficient contributions to pooled funds), respectively, shift the financial burden of care back onto persons with chronic health conditions.

The paper concludes with several recommendations for addressing high OOP spending on medicines. Of course, general strategies for financial protection are applicable and can be considered as part of a package of UHC reforms. These include: (i) increasing public spending on health; (ii) redesigning coverage policies; and (iii) strategic purchasing reforms. However, targeted strategies can also make progress on NCD and mental health medicines specifically. These include: (i) price reduction policies such as price negotiations, removal of tariffs, and direct subsidies by ministries of finance; and (ii) limitation or elimination of user charges for persons with NCDs and mental health conditions. Some countries will also need to consider policies that strengthen supply chains for essential NCDs and mental health conditions.

Paper 6: Human resources for health: How to increase workforce inputs to address NCDs and mental health conditions?

NCD and mental health interventions cannot be delivered to all who need them without a skilled health workforce. The health workforce gaps in low- and middle-income countries are well established, and many solutions have been proposed. Paper 6 seeks to provide recommendations on health workforce development for NCD and mental health care specifically.

One of the most important actions that countries can take to address this problem is to improve pre-service training in chronic disease prevention and management, especially in schools of nursing and advanced practice that train the bulk of primary healthcare workers. Curricula need to be revised to include sufficient training in essential competencies for common conditions like hypertension, diabetes, and depressive disorders. Since some interventions require specialized competencies, training programmes can consider creating specialty tracks tailored to specific workforce needs. This is especially true for mental health.

Countries also need to explore ways to upskill health workers who are already in service. There are numerous examples of task-sharing initiatives for specific components of chronic disease management; what is less clear is how to scale these programmes and sustain them over time. The quality of care for chronic diseases is often suboptimal, even in relatively resource-rich countries. Results-based financing mechanisms have shown promise but need more research. Organizational-level initiatives like these need to be complemented by system-level initiatives like fair remuneration and revisions to licensing and regulation.

The paper includes a modelling exercise to estimate a global price tag for the additional health workforce requirements for essential care for NCDs and mental health (estimates forthcoming). While these costs should be borne primarily by national governments, development assistance can help jumpstart new training programmes. Regional initiatives might also play an important role, especially for training specialist physicians in fields like cardiology, oncology, and psychiatry.

Paper 7: Galvanizing investment, action and accountability in NCDs and mental health: the role of civil society

The country case studies in Paper 4 highlight how an active, participatory social dialogue is critical to making progress on NCDs and mental health. Paper 7 explores this issue further. The paper outlines the many ways in which civil society organizations (CSOs) can influence the health financing process, from advocating for resources for new disease programmes to holding governments accountable for their financial commitments. As partners with governments, they can also aid in policy implementation, for example by being the “face” of mass media campaigns or facilitating patient support groups for chronic disease self-management.

Still, CSOs need financial support to do their job well. In countries without a large domestic philanthropic sector or government budget for public–private partnerships, CSOs may need to secure funding from sister organizations internationally. The World Heart Federation’s World Heart Grants programme is one among many examples of successful programmes.

Paper 7 concludes with four recommendations for ###. First, governments and international institutions need to make sure CSOs are given a seat at the table in policy processes. Second, governments and donors need to invest in developing local CSO capacity. Third, CSOs need to actively engage with governments to generate demand for NCD and mental health programmes and services. Fourth, governments need to task CSOs with implementation and accountability.

CONFIDENTIAL