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Financing for NCDs and mental health: **Where will the money come from?**

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Policy Brief

Introduction

Noncommunicable diseases (NCDs) and mental health conditions represent a significant and growing challenge to public health and sustainable development worldwide. Increasing levels of illness, disability, and mortality are largely driven by high exposure to risk factors (such as smoking and obesity), as well as population growth and aging.[1,2] Additionally, the COVID-19 pandemic highlighted the vulnerabilities of people living with NCDs, particularly when these conditions were untreated, putting individuals at higher risk of severe COVID-19 outcomes, including mortality. The pandemic also led to increased rates of mental health conditions and engagement in risky behaviors, such as harmful alcohol use.[3] This growing burden not only threatens collective health and well-being but also undermines societies and economies, given the substantial expected losses in human capital and capacity.

National policy responses have generally not kept up with the health needs of populations, in part because of limited fiscal capacity; dire macrofiscal conditions in the wake of the pandemic have made this situation even more difficult in many countries.[4] Because of low levels of public spending on NCD and mental health services, most spending comes from households in the form of out-of-pocket (OOP) payments, especially in lower-income countries.[5] Without adequate funding for targeted, cost-effective NCD and mental health interventions, avoidable deaths and disabilities occur, and this also hinders economic growth.[6] External resources from development assistance for health (DAH) are an important source of financing in the poorest countries, but a relatively small share of this is explicitly focused on NCDs and mental health,[7] and in any case, reliance on external funding is not consistent with sustainability.

This policy brief reviews the options for increasing funding for NCDs and mental health from the perspective of health ministries, finance ministries, and development agencies. This policy brief complements another policy brief, *Financing for NCDs and mental health: making the money work better*, that identifies mechanisms for improving the efficiency of current spending. These recommendations emerged from the International Dialogue on Sustainable Financing for Noncommunicable Diseases and Mental Health (June 2024) and related technical background papers.[5,8,12] **Four key messages** emerged:

1 Most of the funding required for NCD and mental health programs will need to come from domestic sources, and public finance needs to increase substantially

Numerous studies have estimated the costs of packages of cost-effective NCD and mental health interventions, including those recommended by WHO.[10,13,14] The cost of an essential package of NCD services implemented at a high level of population coverage is estimated to be around 0.1% of GDP for the average middle-income country, and up to 0.4% of GDP for the average low-income country. For mental health, an essential package would be around 0.1% and 0.2% of GDP respectively. Achieving these spending levels would require a several-fold increase in NCD and mental health spending in most lower-income countries.[15] Most of the resourcing for these packages would be for expanding clinical services (including prevention) in primary health care settings.[15] While the additional share of GDP that is needed for these services in any particular country will depend on current spending levels, service coverage, and how well the resources are being used, these estimates provide a sense for the overall level of resources that would need to be allocated to the health sector to fully fund the essential packages identified for these conditions.

The low levels of public spending on NCDs and mental health that have been observed in many countries are the result of several factors. Most of these are not unique to NCDs and MH: low government revenue (resulting from low growth, inefficient and insufficient tax collection, or both), limited fiscal space (partly due to debt pressures), and low prioritization of health within government budgets. Hence, even when NCDs and mental health conditions are prioritized within the health budget—as is the case in some, mainly higher-income countries[5] —the absolute level of spending is incommensurate with the need for services. Private (mainly OOP) spending thus comprises the majority of spending in most low- and middle-income countries.[5] OOP costs lead to catastrophic levels of spending when they are high, exacerbating the “poverty trap” that many vulnerable populations already face. Even when OOP costs are not very high (e.g., user fees for primary health care services), they can still lead to under-utilization of essential services, including preventive services, and when incurred on a recurring or chronic basis, may still contribute to financial hardship.[16]

In some settings, (private) voluntary health insurance has emerged. Voluntary health insurance has never been the core of a universal health coverage system and it typically covers only richer segments of the population. It can also affect the incidence of benefits of public spending wherein the already-scarce specialists in public facilities preferentially serve the privately-insured minority of the population.[17] Additionally, market failures and the chronic nature of NCD and mental health conditions may also limit access to private insurance due to risk segmentation and selection. When compared to pooled funding from general taxation and/or social health insurance contributions, neither OOP spending nor voluntary insurance is efficient or equitable. To make progress towards universal health coverage, public finance will need to increase substantially to reduce reliance on private finance, including for high-priority NCD and mental health interventions.

2 Health taxes are essential for tackling NCD risk factors and can generate more revenues, making them a win-win for governments

WHO and the World Bank have produced a range of guidance on health taxes, emphasizing specific excise taxes on tobacco, alcohol, and sugar-sweetened beverages.[18-21] Numerous studies have shown that these taxes are a win-win: they are effective at reducing consumption of unhealthy products and improving NCD outcomes; thus also potentially reduce the pressure on future health spending on costly treatment and care; and they provide additional revenues for governments.[9] They do not significantly harm economic growth or employment, and the impact on illicit trade is generally insignificant. Furthermore, when the cost of averted healthcare spending and health effects are considered, health taxes are often pro-poor.[22]

Health taxes can and do generate substantial government revenues, but are not sufficient on their own; broader tax policy and administration reforms are also needed (as indicated above). What is attractive about health taxes—compared to other kinds of taxes like value-added taxes—is the speed of the revenue gains and their relative administrative simplicity.[21] Many public health advocates have called for health tax revenues to be earmarked for health. Evidence from country experiences suggests that the resource gains for the health sector would actually be quite small,[23] but they could be allocated to public health prevention programs or to short-term "catalytic" initiatives (see below) to make them more politically palatable.[18] If earmarking is desired, "soft" earmarks (i.e., where revenues are committed to specific purposes but are nonbinding and somewhat flexible) are preferable to "hard" earmarks enshrined in legislation.[18] Irrespective of decisions on earmarking, health authorities making the case for increased public funding should not lose sight of the "big picture" (the overall public resource envelope) in their dialogue with the finance authorities rather than focusing solely on earmarks.

An emerging source of concern is the large subsidies that incentivize consumption of products that worsen NCD outcomes. Chief among these are fossil fuel subsidies and agricultural subsidies on commodities (e.g. sugar, rice, corn, beef, and milk) that are used to make obesogenic products.[24] Of course, these subsidies also harm the environment and comprise a considerable share of government spending in many countries.[25] While removal of subsidies can be politically very challenging, and needs to be accompanied by mitigation measures to protect socioeconomically disadvantaged groups, it represents a potential win-win-win: win for health, win for climate change mitigation, and win for government budgets. While subsidy removals have proven to be politically acceptable and effective in some countries,[26] further research is needed on the political economy of implementing reductions in harmful subsidies.

3 DAH can play a catalytic role in getting NCD and mental health programs going, especially in countries where significant capital investments are needed

DAH continues to play a significant role in supporting communicable, maternal, perinatal, and nutritional disease services, especially in low-income countries.[27] However, calls for DAH to fill the gap in NCD and mental health funding have never taken a significant hold, and the share of DAH allocated explicitly to NCDs and mental health remains quite low.[27] While increases in DAH for NCDs and mental health are necessary, financing of NCD and mental health services and programs (as well as health services more generally) remains principally the responsibility of national governments.[7]

DAH committed for NCD or mental health programs should be seen as a time-bound allocation of funding to kickstart a new health initiative over the short- or mid-term — not a long-term source of finance. This "catalytic" role for DAH needs to be made explicit at the very start of the initiative. Other features of catalytic DAH initiatives include:

- Intent to accelerate or enable national actions that are already outlined in national NCD and mental health plans and strategies but are under-resourced
- Use of funds to overcome known barriers to program implementation/scale-up, e.g., workforce development, investments in innovative service delivery modalities, transitions to digital information systems, etc.
- Taking the form of "short-term infusions" linked to specific implementation and policy outcomes, e.g., integration, sustainability, and full government ownership (including finance) of the health program(s) in question, including integration into the government's overall public finance framework

Several successful examples of DAH catalytic funding have been reported in recent years, including for workforce development, construction of specialized facilities, and support for implementing NCD prevention legislation.[8] Financing recurrent costs (e.g., medicines, personnel) is generally seen as an ineffective use of catalytic funding, although exceptions apply, notably in low-income countries and humanitarian settings.[8] The technical background paper on DAH that was prepared for the International Dialogue on Sustainable Financing for Noncommunicable Diseases and Mental Health explores these issues further.[23]

4 DAH can be used to finance public goods to tackle NCD and mental health issues and support action at the regional and international levels

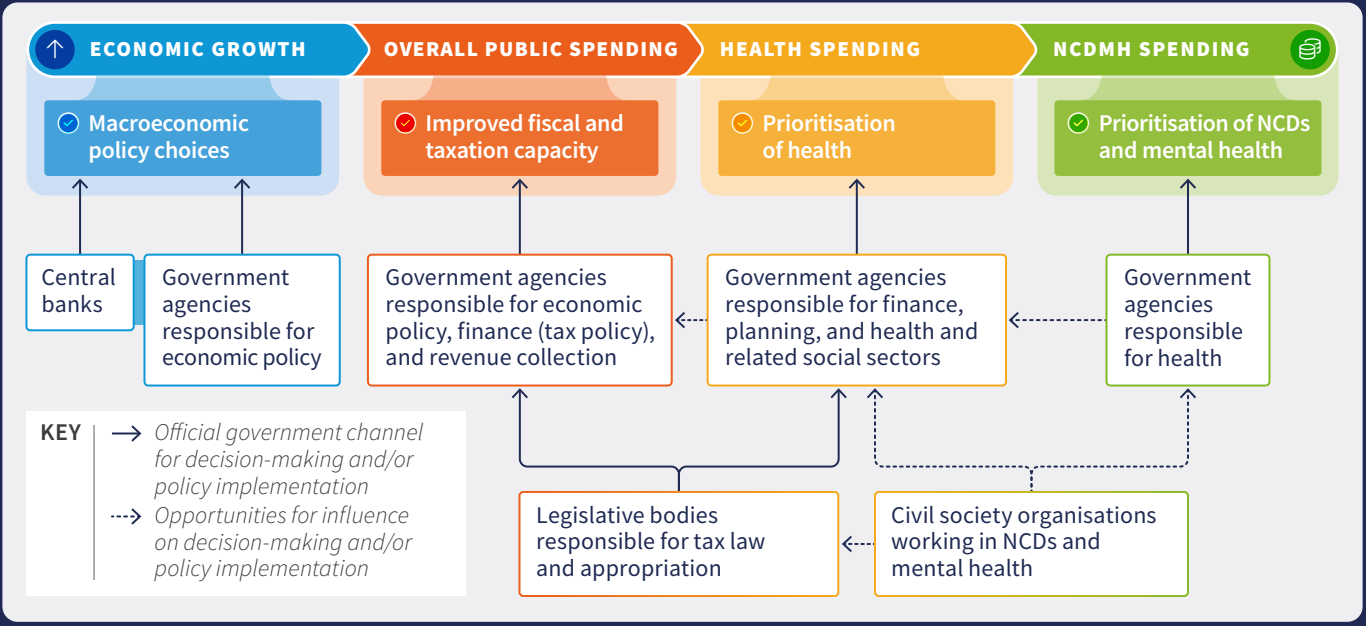
In addition to country-level investments, DAH could be leveraged to foster collaboration among groups of countries or international organizations to achieve greater impact on NCDs and mental health.[28] First and foremost, DAH can support the development of public goods that can be used by many countries at the same time. Examples include new products (e.g., fixed-dose combinations of chronic medicines, to support adherence), policy tools (e.g., for tracking service coverage or costing health programs), and innovations in care delivery (e.g., community-based models for long-term care services).[8]

DAH can also address cross-border threats like tobacco smuggling and air pollution by supporting harmonization of laws and regulations across porous country borders.[8] Finally, DAH can help foster global and national leadership on specific disease initiatives and counter industry influence.[8]

Conclusion

National governments have signed up to the health-related SDGs, which include action on NCDs and mental health.[29] To deliver on these commitments and act against their already massive but still increasing health and economic impacts, more public funding will be needed for health systems.[30] This brief provides recommendations on how to increase the overall resource envelope for NCDs and mental health. The figure provides a framework for considering how different actors can work together towards this objective.

Increasing the overall resource envelope for NCDs and Mental Health



While health ministries can determine how to allocate resources to NCD and mental health services and programs, they have less influence over the appropriation of resources to the health sector more generally, and much less on overall macroeconomic policy and fiscal capacity—the main driver of public spending levels. Countries that have successfully increased spending on NCDs and mental health have done so through multisectoral partnerships that include non-health stakeholders within finance and planning ministries, legislatures, and civil society organizations.[10] Non-health ministries (e.g., finance, agriculture, and environment) and legislatures are critical to addressing NCD risk factors, and civil society organizations are critical to advocating for greater health spending, holding governments to account, and supporting intervention implementation.[12] The primary objective of these partnerships is to increase the size of the pie for the health sector and, over time, to increase the share of the pie devoted to NCDs and mental health as needed to respond to an increasing disease burden. As a complement to increased domestic health spending, increased use of health taxes and removal of harmful fossil fuel and agricultural subsidies can help free up some additional government resources and address NCD and mental health risk factors. DAH can be a time-bound allocation of external funding to support this process of giving increasing priority to NCDs and mental health and mobilizing long-term sustainable domestic financing for these conditions.

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