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Financing for NCDs and mental health: **Making the money work better**

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Policy Brief

Introduction

Since the 2000s, economic growth, population aging, and the continued epidemiological transition towards noncommunicable diseases (NCDs) and mental health conditions have led to greater health care needs for these conditions in nearly all countries.[1,2] Yet countries face three inter-related problems in financing their health systems, including NCD and mental health services. First, the level of government spending remains insufficient to meet population needs for essential NCD and mental health services.[3] Second, and consequently, households are covering the shortfall in public funding by spending out-of-pocket (OOP), which is inequitable and may impede best health outcome for people living with a chronic condition.[4] Third, much of the current spending is not going towards the highest-value interventions.[5]

In the wake of the COVID-19 pandemic, many national governments face significant macrofiscal challenges that make increasing resources for NCDs and mental health more difficult.[6] Hence, the challenge for the coming years is to improve financing for NCDs and mental health in the context of tighter health budgets. This policy brief reviews the options for governments to improve and get better value for money in their spending on NCDs and mental health. It also identifies options for ministries of health to use discretionary funds to support increased effective coverage of NCD and mental health interventions. This brief complements another policy brief, *Financing for NCDs and mental health: where will the money come from?*, that identifies mechanisms for increasing financing for these conditions. These recommendations emerged from the *International Dialogue on Sustainable Financing for Noncommunicable Diseases and Mental Health (June 2024)* and related technical background papers.[7-11] **Four key messages** emerged:

1 The policy response to NCD and mental health conditions needs to include a greater focus on publicly financed, PHC-based services

It is well known that overall health spending and the share of health spending from public sources is positively correlated with national income.[12] As would be expected, analyses of available national health accounts data from 59 countries suggest that NCD and mental health spending is also positively correlated with level of country income.[7] (Of note, national health accounts are not available for all countries; in many, there is no detailed information by disease category, and the quality of the data varies.) Regarding the source of funds, data for a selected group of lower-income African countries shows that on average, 74% of spending is private (mostly OOP), with governments contributing only 21%.[7] Over half of NCD and mental health spending is on treatment, including hospital care;[7] primary health care (PHC) services are relatively under-funded, resulting in low access to and coverage of preventive interventions. (Under-reporting of NCD and mental health spending in PHC also makes it difficult to reliably assess spending levels and trends.) Much of the OOP spending on NCDs and mental health appears to be on medicines—including those that are considered essential and thus should in principle be financially accessible to all.[11]

Several studies have demonstrated the high returns from greater investment in well-prioritized, highly cost-effective NCD and mental health services, with benefit-cost ratios ranging from 3.3-5.7 for mental health conditions[13] to 7.0-19 for NCDs.[14-16] Nearly all these interventions are delivered in PHC settings. Yet governments still face considerable pressure to spend more on costly tertiary care treatments at the expense of PHC. This is one part of a vicious circle, though: access to quality PHC services varies widely within and across countries,[17] reinforcing a lack of confidence in the public system and tempering interest in greater PHC spending. This pressure needs to be resisted if governments are to make the best use of their limited resources and deliver on their commitments to UHC. The policy response to NCDs and mental health must therefore continue to emphasize efforts to strengthen PHC, and efforts to strengthen PHC must include these conditions as guideposts.

2 The principal way to improve the value in NCD and mental health spending is to change the incentives around how resources are allocated to providers and then used

Since adoption of a universal health coverage target as part of the health-related SDGs in 2015, numerous countries have embarked on revisions of their health benefit packages. Often these packages have been expanded to include more NCD and mental health interventions. However, a review of country experiences suggests that these packages often serve primarily as advocacy documents that do not lead to greater budgetary allocation or intervention coverage.[18] This is because packages are infrequently (and/or not explicitly) linked to financing mechanisms and budgeting processes.[19] Addressing this disconnect is essential to ensuring that NCD and mental health interventions are fully implemented and that the package can be translated into practice. Focusing on allocative efficiency (i.e., prioritizing cost-effective interventions) is necessary but will remain at the level of intention if budget formulation and distribution remain input-based rather than focused on service outputs.

NCD and mental health services have unique characteristics that need to be considered in the design of both health care delivery systems and associated health financing arrangements.[10] Chronic disease management requires an integrated approach to delivering and purchasing services across the continuum of care (e.g., PHC-based management of hypertension coupled with treatment of acute cardiovascular events and rehabilitation) and adequately deals with comorbidities (e.g., diabetes and chronic kidney disease, as well as depression), with sufficient empowerment of the person living with these condition(s). Unfortunately, many health care financing systems are not yet organised along these lines.[20]

The transformation will require, among others, changing how health care providers are remunerated; countries will have to move away from historical models such as rigid line-item budgets (for public sector providers) and fee-for-service (for private providers) to approaches more favorable to integrated care for chronic conditions.[21] In countries with fragmented coverage programs and pooling arrangements, harmonization of underlying data and payment systems can mitigate the harmful implications of this for care continuity, particular as people transit from one coverage program to another.[22] With economic growth, population aging, and increased availability of costly technologies, it will become increasingly important to implement financing arrangements that can control unproductive cost escalation, including cross-country learning and exchange on good practices.[2]

Crucially, many countries will have to fit these institutional changes within broader policy action and reforms. Some countries could generate substantial additional resources by improving public financial management.[23] Additionally, moving towards effective use of digital financial and health information management systems could greatly facilitate the delivery of high-quality PHC and chronic disease care in particular.[24] Health systems would greatly benefit from having one information platform that is shared across actors, institutional capacity to conduct analyses to improve efficiency, clinical outcomes, financial protection and fairness, and accountability mechanisms for public-sector performance.[10]

3 NCD and mental health policy leaders have several "entry points" for using existing funding more effectively

The main mechanism for increasing spending on NCDs and mental health is by increasing revenues appropriated to the health budget and subsequently devoted to spending on services that are specified in health benefits packages. But greater allocations to the health budget are not always feasible. When available, discretionary budgets can be allocated to NCDs and mental health for disease- and intervention-specific activities. While these budgets are small relative to the pooled funds used mainly to purchase clinical services, they can still make a big difference on implementation, service utilization, and outcomes.

Country case studies undertaken for the Dialogue illustrated the potential ways that ministries of health can use discretionary funds to improve NCD and mental health outcomes, as summarized in the table below.[25] Their inclusion in the table does not constitute a blanket endorsement; the effectiveness of any one approach is context-specific and needs to be carefully designed and evaluated. Additionally, discretionary funding could be pooled across departments or units to achieve shared goals, such as improving NCD and mental health care among people living with HIV.

Category	Example from country case studies
Fiscal interventions*	Tobacco, alcohol, and SSB taxes
Non-fiscal interventions*	Regulations on alcohol and tobacco sales
Measures to drive down prices	Removing import tariffs and taxes on essential medicines
Population-based health interventions	Mass media health promotion campaigns
Measures to improve effective coverage	Community-based screening programs
Targeted subsidies for key commodities	Dedicated funds for cancer drugs
NCD/mental health unit-specific activities	Agenda-setting and policy development

** These refer to interventions that are implemented by non-health ministries, in contrast with "population-based interventions" that are implemented by public health agencies. For these interventions, ministries of health could use discretionary funding to support relevant analytical work and advocacy rather than to finance implementation.*
SSB = sugar-sweetened beverage.

As a rule of thumb, these activities are much less costly than spending on clinical services, and they can play an important role in supporting or enhancing clinical care. For example, taxes can reduce risk factor prevalence and thus prevent mortality and reduce demand for health services over time.[26] As another example, upstream price-related measures like pooled procurement can enable more people to benefit from services to more persons (i.e., buying more units of a given medicine) and thus enhance the potential public health impact within a fixed budget.[27]

4 There is urgent need to implement policies that improve access and financial protection for individuals needing essential NCD and mental health services

A range of studies have found that NCDs and mental health conditions account for much of the financial distress that is experienced worldwide from seeking medical care, and that this is directly related to insufficient public finance and excessive OOP spending on services[4] as well as to inadequate financing mechanisms that get the most from that limited funding. Although high-cost treatments and acute events receive much attention and prioritization, the "slow burn" of recurrent OOP spending on chronic disease care (including medicines) appears to be a major driver of financial hardship.[11] Further, affordability of care is closely related to access to care. When services have to be paid for OOP, individuals tend to forgo necessary care, including cost-effective preventive care and early treatment.[28]

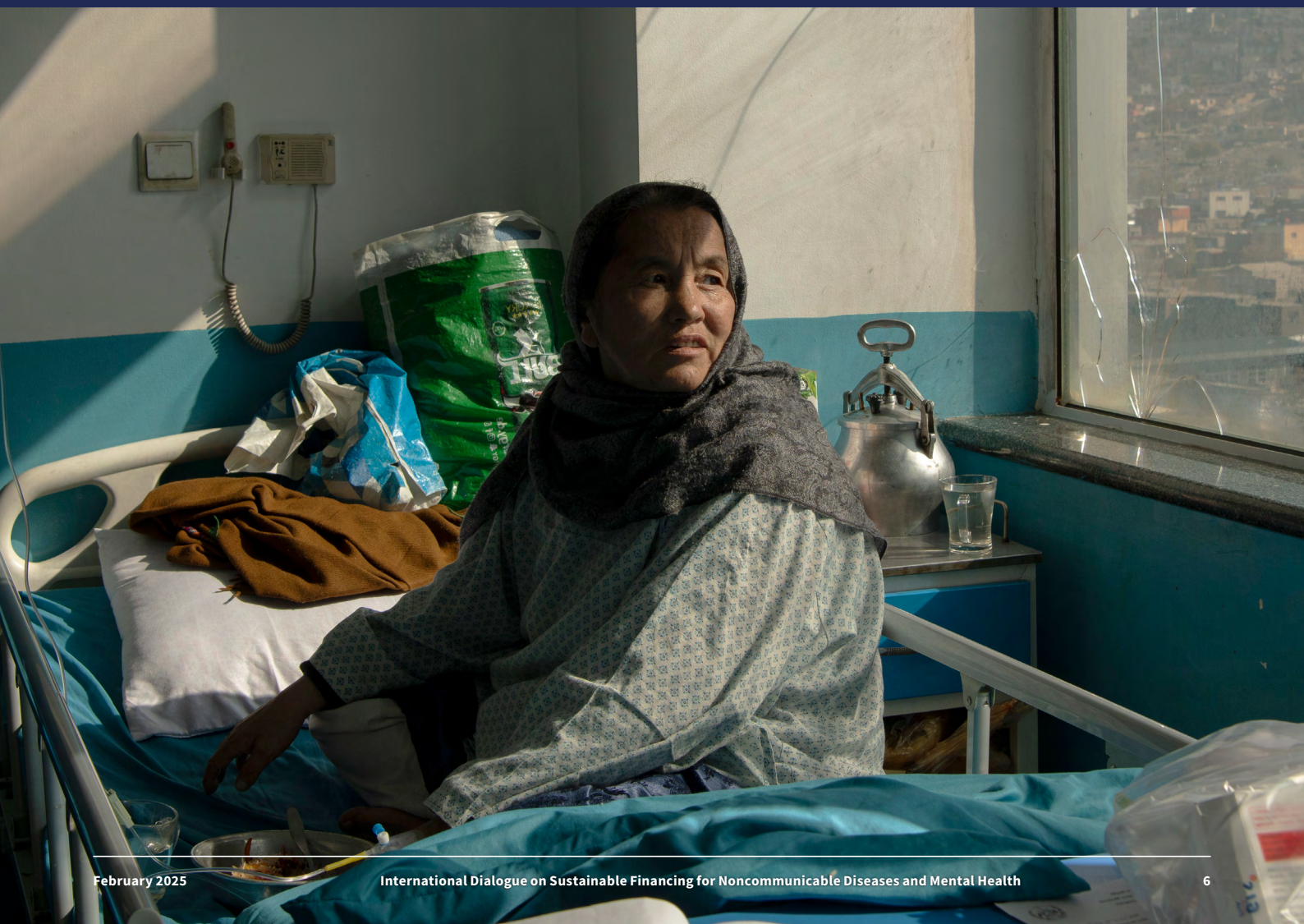
Measures that improve access to care, including by making medicines more available in public facilities, can also lower OOP payments by reducing travel times and spending, as well as payments for medicines (e.g., from private retail pharmacies). In this way, improving NCD and mental health services through PHC, as key means to enhance progress towards UHC, are intertwined agendas. Hence, meaningful progress on UHC needs to include progress on access to and affordability of priority NCD and mental health services.

There are specific strategies that policymakers can use to ensure financial protection for priority populations and interventions.[11] The first is to lower the prices of key commodities, especially medicines. Regulations and/or negotiations with manufacturers of these commodities can greatly reduce prices, and pooled procurement can generate additional economies of scale. An important target for many countries is the removal of tariffs (or customs) on essential medicines.[11] The second is to eliminate or put explicitly fixed limits on user fees and copayments. Full exemption is especially important for individuals with low incomes and those with chronic NCD and mental health conditions who are similarly vulnerable. Where they remain, copayment policies should move from percentages of the charge to fixed (low) amounts to reduce uncertainty for patients; ceilings could also be set on maximum yearly total amount of copayments.[11] Additionally, dedicated schemes or funds[25] that cover very high-cost services (e.g., cancer treatment) might be merited in some cases, to ensure that treatments are available to those who need them without fear of high out-of-pocket costs. While these are general strategies for reducing OOP payments, they need to be designed with individuals affected by NCD and mental health conditions in mind, since these conditions are major drivers of financial hardship and thus hinder progress on UHC.

Greater collaboration with and effective oversight of the private sector could also improve access and financial protection; for example, by ensuring that essential medicines are available at low cost through private retail pharmacies.[29] Other policies could build on these to improve access to medicines and/or provide more comprehensive financial protection,[30] but action on OOP payments for medicines, though challenging in practice, will be a priority for attention in most countries.

Conclusion

The 2025 UN High-Level Meeting represents an important opportunity to take stock on the NCDs and mental health and recommit to increasing and improving financing for these conditions. The strategies recommended in this brief represent an ambitious but concrete policy agenda that acts at the intersection of NCD- and mental health-specific activities and general health system and health financing arrangements. Thus, improving financing arrangements for NCDs and mental health is the shared responsibility of those who work in both domains. Progress on Universal Health Coverage must include progress on access to affordable, high-quality care for NCDs and mental health conditions.



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