World Health Organization | WORLD BANK GROUP

International Dialogue on Sustainable Financing for NCDs and Mental Health

Synthesis of Technical Background Papers

Part 1: Setting the Scene

In 2018, the Government of Denmark and the World Health Organization (WHO) co-organized the first Global Dialogue on Partnerships for Sustainable Financing of Noncommunicable Disease (NCD) Prevention and Control. The Dialogue generated a range of recommendations for countries to increase financing for NCDs to accelerate progress towards the Sustainable Development Goal (SDG) 3.4 target on NCD mortality.[1] This effort built on years of hard work to maintain momentum following the first UN High Level Meeting on NCDs in 2011. In fact, the past decade offered signs of hope for dealing with NCDs, with a steady growth in policy-relevant evidence and international experience implementing NCD programs. Although it was acknowledged at the time of the first Dialogue that many countries would struggle to reach the SDG targets, there was a sense of optimism that governments and major donors would devote more resources to NCDs.

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Unfortunately, the COVID-19 pandemic knocked the NCD agenda significantly off course. Persons living with NCDs were the most affected by the pandemic, and utilization rates of chronic disease services fell precipitously.[2] Goals for routine preventive care like cancer screening have been slow to recover.[3] What is more, the mental health consequences of the pandemic, combined with increased levels of migration and conflict in several parts of the world, have elevated mental health as a top health priority in many countries. A positive aspect of these calamitous events is that there is new interest, acceptance, and appetite to advance the public mental health agenda, which opens new policy windows for policy.[4]

Still, in the wake of the pandemic, macro-fiscal risks have shifted towards the downside for many countries, with slow growth, inflation, and debt burdens pressuring public budgets and exacerbating social inequalities and impoverishment.[5] Progress towards universal health coverage (UHC) has been slow, with two-thirds of countries seeing stagnation or increases in rates of catastrophic out-of-pocket (OOP) spending on health, and most countries seeing little or no improvement in coverage of most key services, including NCDs.[6] Geopolitical realignment and armed conflict are on the rise, distracting some countries from implementing their health policy agendas. The global community is struggling to act on climate change. The list of challenges goes on. Thus, the challenge for NCDs and mental health in the coming years is to secure appropriate investment and provide financial protection within a highly constrained macro-fiscal environment.

Against this backdrop, the WHO and World Bank are convening an International Dialogue on Sustainable Financing for NCDs and Mental Health (hereafter, “Dialogue”). This Dialogue will revisit the recommendations from the 2018 event, considering the changed world today. In view of the frequent co-occurrence of NCDs and mental health conditions and shared approaches to their appropriate management within health systems, the Dialogue explicitly and fully includes mental health. It seeks to identify policy options and strategic approaches that enable and enhance the integration of high-value NCD and mental health interventions into national health and financing systems.

In preparation for the Dialogue, several technical background papers were developed to summarize the evidence for effective financing policies and actions. The process included consultation with an External Technical Expert Group (ETEG), multidisciplinary teams at the WHO, World Bank, and external partners. The papers drew on literature review, secondary analyses of expenditure data, desk reviews of policy documents and publications from 14 case study countries, and key informant interviews with NCD and mental health stakeholders in international organizations and in several countries. This document seeks to summarize the technical background work and organize it into thematic areas that specify opportunities for action. Where countries are named in this document, the content draws on evidence and examples from those case studies, which will be published after the Dialogue.

Part 2: Where are we now?

Trends in NCD and mental health spending should be understood within the broader health spending context. An analysis of the WHO Global Health Expenditure Database provides insights into long-term trends in health financing and its sources. For many countries, the 2000–2009 period was a "golden age" for health spending because of rapid economic development. In lower-income countries, it marked a period of steady growth in development assistance for health (DAH) to support the Millennium Development Goals and other donor interests. The years 2010–2019 saw deceleration in economic growth in many countries, with concomitant slowing in the rate of growth in government spending on health and DAH. The COVID-19 pandemic led to a resurgence in government spending on health and short-term infusions of DAH, mostly for pandemic response. Since the pandemic, trends in health spending have returned to patterns that look more like 2010–2019 for many countries and bleaker for countries facing significant economic downturns.[7]

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The reason these trends are important is that the share of total health spending on NCDs and mental health has tended to increase or at least remain stable as incomes rise. Part of this is due to increasing demand for health services overall, but in these same countries epidemiological and demographic shifts have been especially rapid, so the need for NCD and mental health care has grown as well. Figure 1 shows trends in the share of total health expenditure allocated to NCDs and mental health from several countries with available data. Unfortunately, in numerous countries the observed growth in total health expenditure (THE) allocated to NCDs and mental health has been driven partly by increased OOP spending by patients and families, raising their financial risk and threatening progress on UHC. Additionally, the share of THE allocated to mental health is much lower than for NCDs.

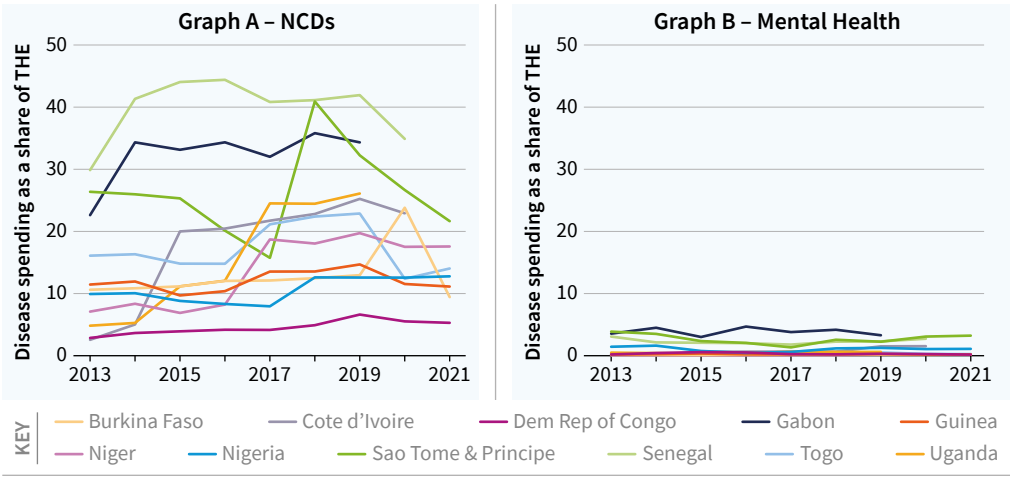


Figure 1 – Trends in expenditure on NCDs (Graph A) and mental health (Graph B) in selected countries.

Source: Data are from the WHO Global Health Expenditure Database.
Note: Expenditure is expressed as the share of total health expenditure (THE) allocated to these conditions.

Much of the increase in OOP spending associated with NCDs and mental health conditions could be due to one of two factors: (i) public sector service provision is inadequate to meet demand, and so many service users must seek care through the private sector, often at their own cost; (ii) purchasers – entities that use pooled funds to pay providers for health services – fail to cover all or most of the costs of commodities, including chronic outpatient medicines, within benefits packages.

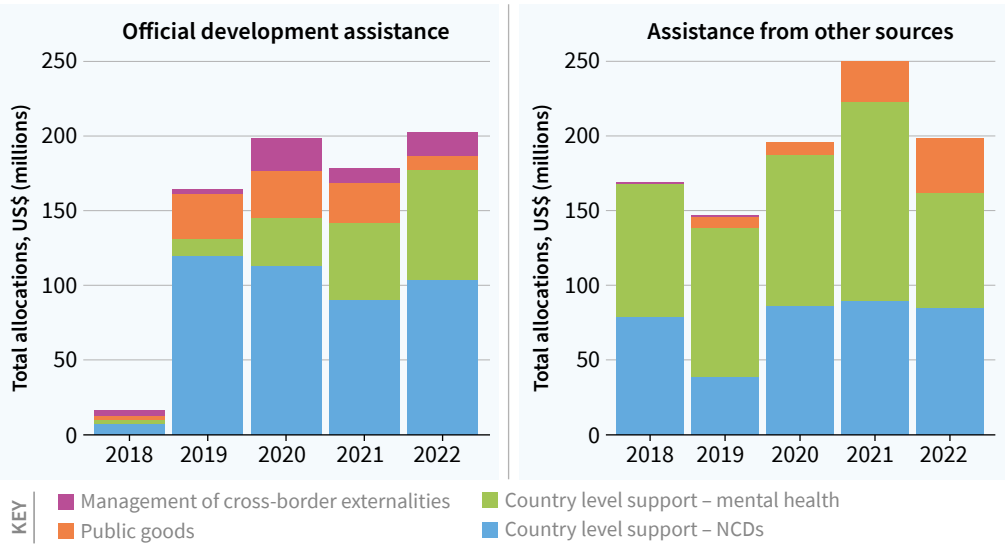
Though these data provide some insights into spending patterns in a handful of countries, it is important to note that they have significant limitations. As one person interviewed for the background papers put it, "we have no idea what's going on" below the surface of these aggregate data in most countries. It is unclear how much funding is going into public health functions and population-level prevention. It is also unclear what sorts of clinical interventions for NCDs and mental health are being funded and how those relate to the contents of health benefits packages. Figure 1 underscores this point: time-series data on

NCDs and mental health spending are only available for a small subset of countries, and the heterogeneity of levels and trends seen suggests a need for more detailed look at the different components of spending. The quality of national health accounts data is also an area of concern for some countries. Future conversations about financing for NCDs and mental health therefore need to start with an acknowledgement that investments in high-quality, timely, detailed financial data on disease- and program-specific spending patterns are lacking in most countries, hindering their ability to develop, implement, and monitor changes in financing policy.

A positive development has been the increasing amount of DAH committed to NCDs and mental health. According to one study, DAH increased by a factor of three between 2011, the year of the first UN High Level Meeting, and 2019.[8] Since 2019, DAH has been relatively stable at around US$300–400 million per year, with about half coming from nongovernment sources like private philanthropies. Adding GAVI's support for human papillomavirus (HPV) immunization would increase these estimates by about 15–20 percent. However, it is important to note that DAH for NCDs and mental health still continues to make up only a tiny fraction of the approximately US$40 billion DAH expenditure per year.

Figure 2 – Trends in development assistance for NCDs and mental health, by function and source.

Source: Data are from the OECD Development Assistance Community database.
Note: Management of cross-border externalities refers to programs that prevent the spread of environmental risks such as air pollution or unhealthy products like tobacco smuggling. Public goods refers to knowledge, tools, and products that benefit many countries, including research. Country-level support refers to projects that primarily benefit one country.



Alongside the relatively low but stable level of DAH, a critical insight and message is that government spending on NCDs and mental health must keep up with needs and demand for services and preventive strategies.

Alongside the relatively low but stable level of DAH, a critical insight and message is that government spending on NCDs and mental health must keep up with needs and demand for services and preventive strategies. Worldwide and on average, the annual growth rate in the number of deaths from NCDs since 2010 has been 1.8 percent, and the number of years lived with disability from mental health conditions has grown at 1.3 percent.[9] This is against the backdrop of a 1.2 percent population growth rate and a 0.43 percent annual increase in the median age of the population.[10] So governments that are increasing their real per capita NCD and mental health spending at rates lower than 1–2 percent per year run the risk of falling further behind population need. Some low- and middle-income countries are achieving this rate of growth, while others are not.

Put another way, population growth, aging, and epidemiological change, all of which are largely inevitable trends, are expected to put more and more pressure on health systems to prevent NCDs and mental health conditions and to provide more health care services at the same time financial commitment to these conditions is flagging. Further, there will be inevitable pressure to include more high-cost interventions for NCDs and mental health as incomes grow, which will further stretch public budgets. Part 3 explores the opportunities for national governments to course correct to better meet the needs of their populations while being mindful of overall resource constraints.

Part 3: Opportunities for improving and increasing financing for NCDs and mental health

What is meant by "improving and increasing" financing?

While population-level prevention and health promotion interventions are critical to addressing NCD and mental health, over 90 percent of the funding that is required to adequately respond to these conditions is for personal health services – clinical interventions that prevent, treat, rehabilitate, or palliate.[11] Yet regardless of a country's specific health financing arrangements, it is difficult to track increases in spending on specific interventions, especially those delivered through integrated platforms like primary care clinics. It is possible to indirectly increase the level of financing for NCD and mental health care by appropriating more funding to the health sector in general. Further, it is possible to indirectly improve the efficiency of financing for NCD and mental health care by moving towards strategic purchasing or investing in more efficient administration of the health system – for example, through digital information systems. Health benefits packages designed around cost-effectiveness evidence can also, in principle, be used to improve financing efficiency by getting more health from a given level of spending. Doing a better job on disease prevention could lead to reductions in spending relative to the status quo and free up pooled funds.

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Apart from these generic measures that influence spending on clinical interventions for NCDs and mental health, disease program managers in ministries of health have other options for directly increasing financing for NCDs and mental health using budgets over which they have discretion. Common examples from country case studies include: (i) population-based interventions, such as mass-media campaigns on tobacco use; (ii) public health and policy activities for specific diseases, such as the development of national cancer strategies; and (iii) measures that influence "effective coverage" of personal health services, such as online mental health screenings.

Outside of the main health financing and service delivery system, non-State actors can finance some activities that support NCD and mental health care, such as awareness raising, advocacy (agenda-setting), research, and their own health promotion and service delivery measures. In some cases, non-State actors can also be contracted to deliver interventions paid through public funds. Additionally, ministries other than health can undertake activities that address NCD and mental health risks, and these activities require dedicated financing for administration. Examples include regulations on trans fats and taxes on alcohol. Of course, taxes also generate revenues for governments.

Figure 3 – Entry points for increasing and improving NCD and mental health financing.

Source: Original figure for this publication.
Note: Actions in blue are targets of disease- or program-specific budgets. Actions in yellow are generic but could be leveraged to increase or improve financing within the core health service financing and delivery system (white boxes) to influence risk factors and disease outcomes (purple)

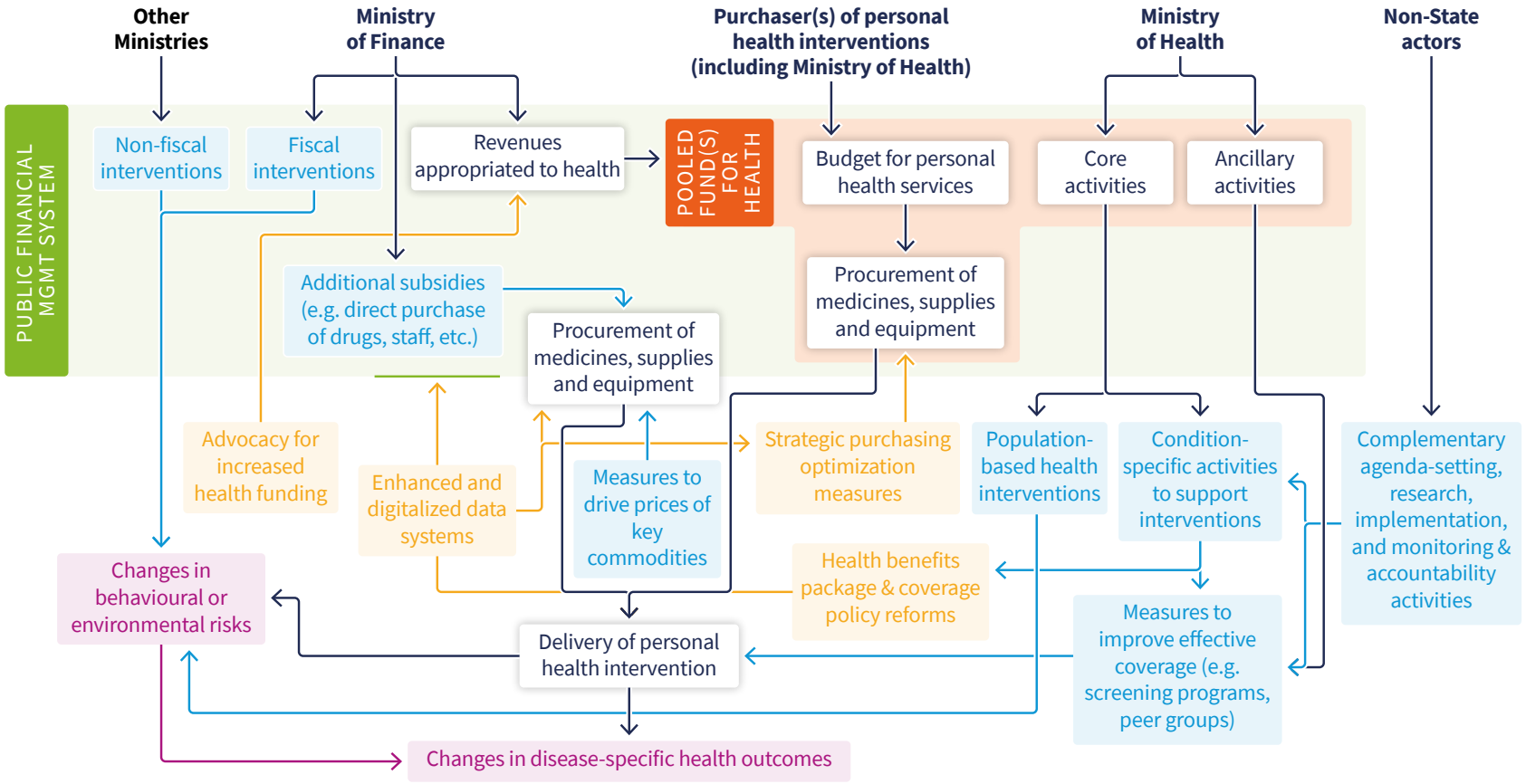

Figure 3 maps these "entry points" for financing NCDs and mental health. Importantly, these should not be construed as vertical programs, but instead as initiatives that enable or support targeted spending on specific diseases and their interventions. Within this framework, the technical background papers and country case studies have identified five major opportunities to increase and improve financing for NCDs and mental health.

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Opportunity 1 – Raising awareness of the unmet need for NCD and mental health care

The problem: A major reason why governments are not devoting more resources to NCDs and mental health is low awareness by decision-makers, affected individuals, and the general population. For example, only half of individuals with hypertension worldwide are aware of their diagnosis; the number is less than a third in low-income countries like Malawi and Ethiopia.[12] People at high risk of NCD or mental health conditions may also be unaware of their risk. Mental health conditions are also underdiagnosed and are highly stigmatized in most of the countries in our case study series, with misunderstandings among the general population about the effectiveness and safety of evidence-based interventions. Additionally, ministry of health units that are responsible for NCDs and mental health suffer from inadequate and inflexible budgets and thus do not appropriately invest in the types of activities shown in Figure 3 that could increase awareness.

Disease advocates can and should join forces to advocate for greater budget appropriation to health overall, with the rationale that "a rising tide lifts all boats."

Potential solutions – general: Disease advocates can and should join forces to advocate for greater budget appropriation to health overall, with the rationale that "a rising tide lifts all boats." Even getting health on the national policy agenda is an important first step in some countries where health is being deprioritized. Ministries of health can seek out productive partnerships with other key ministries, including finance, as well as legislators, civil society groups, and academic researchers with an interest in health. The case studies show that in countries where more resources are being devoted to NCDs and mental health, like Chile and Philippines, durable multisectoral coalitions are a major factor. These coalitions are also an important accountability mechanism. Additionally, low screening and diagnosis rates are often due to health workforce gaps, especially in primary health care facilities. Initiatives on health workforce development, particularly capital investments to increase the number of health workers, could have a spillover benefit for NCDs and mental health by increasing detection and patient demand for care, which could then justify further increases in spending on these conditions. Changes can be made to budget development processes. In many settings, annual health budgets are based more on historical utilization or even allocations than future forecasting of need. Proactive budgeting to prepare for scale-up of essential services could enhance screening and diagnosis, justifying further appropriations over time and creating a virtuous financing cycle.

Potential solutions – condition-specific: For health ministries that want to do more on

NCDs and mental health, an important first step could be to ensure that disease program-specific activities such as those shown in Figure 4 are adequately resourced. Compared to spending for individual health services, these activities have relatively modest costs, but they can catalyze greater action. In countries like Ghana and Ethiopia, researchers and civil society organizations are key to ensuring that problems are documented and that needs are measured, and this can enable and buttress advocacy efforts for specific diseases. What is needed is a standardized menu of options for high-impact programs and activities that disease units can choose from, perhaps drawing from successful models in exemplar countries in each region. Another necessary step is to ensure that essential NCD and mental health interventions are explicitly listed in health benefits packages. While inclusion itself does not itself guarantee financing and access, it can raise awareness on their importance and help foster public demand.

Disease units need not work in silos; there are many opportunities for collaboration and synergy, such as cardiovascular prevention in people living with human immunodeficiency virus (HIV), mental health care and support for persons living with cancer, and diabetes care in populations at high risk of tuberculosis.

Disease units need not work in silos; there are many opportunities for collaboration and synergy, such as cardiovascular prevention in people living with human immunodeficiency virus (HIV), mental health care and support for persons living with cancer, and diabetes care in populations at high risk of tuberculosis. The implication for the financing system is that ministries could conduct cross-programmatic analyses to identify synergies and generate new ideas. At a minimum, programs and units could participate in joint planning and budgeting. A more ambitious opportunity would be to use pooled budgets to achieve shared results. Highly constrained health ministries can also partner with non-State actors to implement disease-specific interventions. For example, the International Diabetes Federation and the Ukrainian Diabetes Federation have played an important role in providing diabetes care in Ukraine.

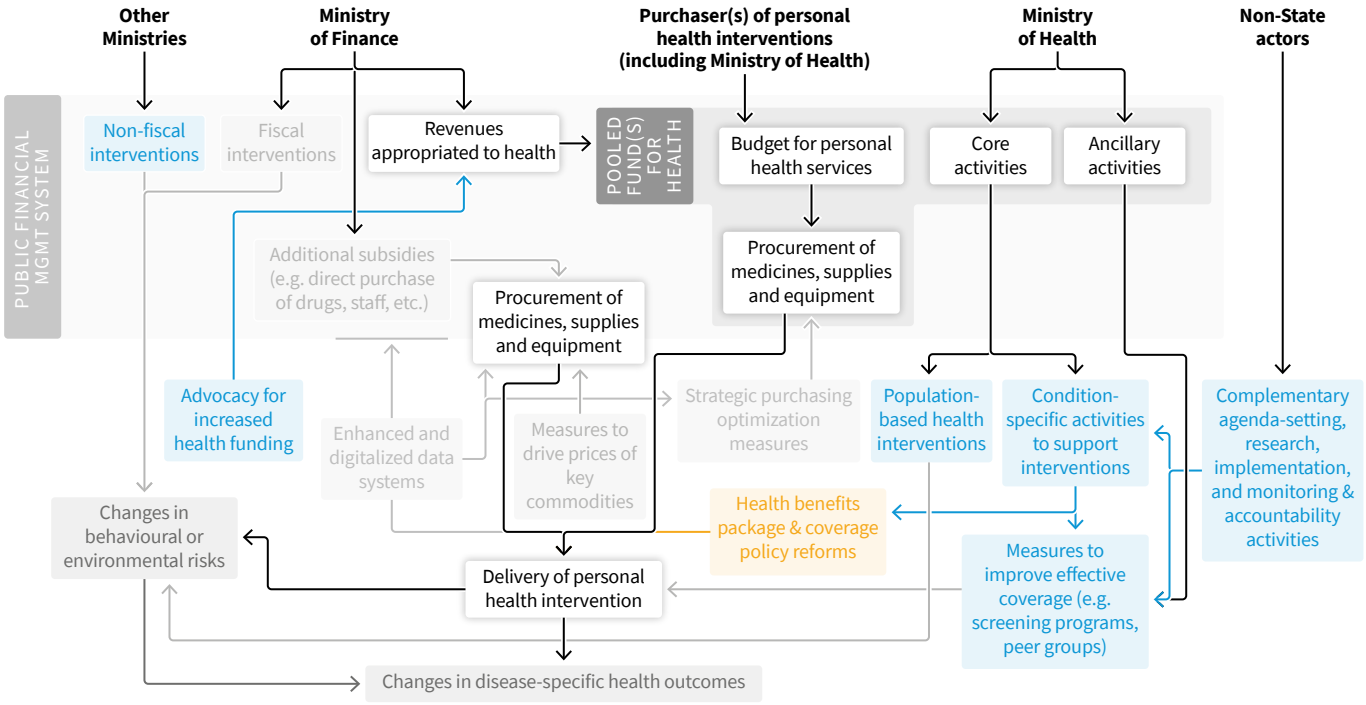

Figure 4. Opportunity #1 for financing NCDs and mental health.

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Opportunity 2 – Tackling risk factors and increasing government revenues through health taxes

The problem: Most countries are making insufficient progress on tackling the major behavioral and environmental risk factors for NCD and mental health conditions, and the risk environment appears to be worsening overall, especially around dietary risks, physical inactivity, and pollution. Intersectoral collaboration among finance, health, and other ministries is usually limited, and in some cases other ministries work at cross-purposes with each other, for example, by propping up alcohol and tobacco industries while financing care for alcohol- and tobacco-related diseases. Industries are also known to interfere in policy processes, often successfully. Even when excise taxes on tobacco, alcohol, and sugar-sweetened beverages (SSBs) have become law, their implementation has been hindered by poor design and administration, limiting their effectiveness.[13]

Measures to improve tax administration overall would also improve the implementation of specific excise taxes on tobacco, alcohol, and SSBs.

Potential solutions – general: Many finance ministries struggle with revenue collection in general. Measures to improve tax administration overall would also improve the implementation of specific excise taxes on tobacco, alcohol, and SSBs. On the other hand, governments spend considerable resources on subsidies that are harmful to health, including on fossil fuels and agricultural commodities, such as beef and corn, that have a negative health and environmental impact. Recent work has highlighted that health, in addition to its role in economic growth, is a critical and independent dimension of the welfare of society, so it should be an objective for national policy in general, not just health policy.[14] Finance ministries could thus take a holistic look at the nature of all their taxes and subsidies and consider reforms that increase or free up revenues to have an overall positive impact on health.

Potential solutions – condition-specific: Most countries could improve implementation of tobacco, alcohol (where relevant), and SSB taxes. Countries like Philippines and Colombia have greatly improved implementation of these taxes in recent years and have become exemplars for health taxes. Technical assistance from the World Bank and IMF was an enabling factor in some cases. Numerous countries have successfully implemented "soft" earmarking of health taxes to public health budget. But earmarking carries considerable downsides, and the size of the health budget increase is usually quite modest, if it ever materializes at all – as observed in Bangladesh – given that there can be and often are offsetting declines in discretionary allocations to the health sector. The WHO has analyzed the role of and evidence on earmarking as part of policy processes and overall health financing, highlighting key considerations for approaching the issue.[15] An important

emerging area for health taxes beyond tobacco, alcohol, and SSBs is ultraprocessed foods; Colombia recently enacted legislation on so-called "junk foods" that included taxes on ultraprocessed foods. It is also important to foster local, national, and regional networks of advocates and experts who can counter industry interference in health tax policy development and implementation processes. This could include civil society – for example, non-State actors, including academia, were critical to the adoption of SSB taxes in Ghana and Pakistan. As a counterexample, Thailand – a country with a strong health system – ranks 10th globally on industry interference in tobacco control, so greater support on these issues is needed.

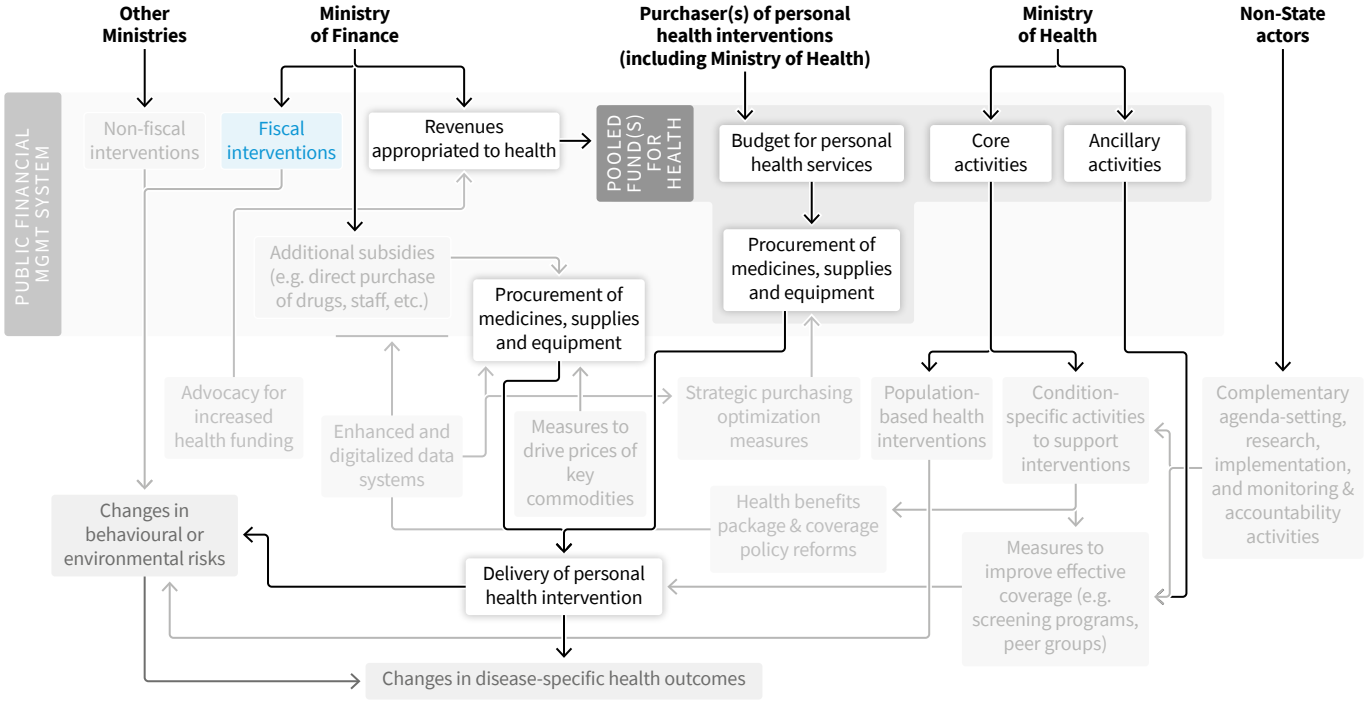

Figure 5. Opportunity #2 for financing NCDs and mental health.

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Opportunity 3 – Providing greater financial protection for people living with NCDs, mental health conditions, and other chronic diseases

The problem: Countries are making very little progress on indicators of financial protection within the UHC target. The available data suggest that it is OOP payments associated with chronic medical needs rather than unanticipated acute events that account for the lion's share of catastrophic health spending in low- and middle-income countries.[6] Still, countries lack timely, local data on the determinants of financial risk and the types of services that contribute the most. Evidence increasingly suggests that OOP spending on medicines is a major factor, though under-provision of services through the public sector – leading to use of costly, loosely regulated private sector services – is also an important concern.[16] What is clear is that budgets for service provision and thus payments to providers are often inadequate, especially for chronic outpatient medicines, resulting in shifting of costs to patients. Social welfare policies for financial protection – for example, fee exemptions for the poor – are also lacking, are missing their target groups, or are not well enforced, partly because of insufficient funding. Low coverage of essential NCD and mental health services in primary care settings in countries like Ethiopia, Ghana, and Malawi means that those seeking care must travel far away for care, and transportation is a major source of spending especially in rural populations. Although such spending is not incorporated into the definition of OOP health spending used for international comparisons and SDG reporting, it is a highly relevant policy consideration in many countries. It is worth stressing that inadequate investment in preventive interventions, including health taxes, can lead to excess spending on costly treatments, often borne by patients.

Potential solutions – general: One opportunity for international organizations and researchers is to develop tools and approaches to help countries better monitor financial risks and their determinants, including health-seeking behaviors and activity within the private sector. In many countries, an early step would be better integration of private providers into pooled funding, though this requires sufficient regulation and oversight to ensure their compliance with public goals around equitable access and financial protection and measures to prevent unproductive cost escalation. Countries with considerable geographic disparities in access to health services could target spending towards expanding high-quality chronic disease care to underserved areas where travel costs are prohibitive to poor households. This applies both to primary facilities and more specialized ones that provide – for example, mental health or cancer services at the community level. Chile and Kenya, for example, have recently invested in health infrastructure to expand

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access to NCD and mental health services. Countries could also explore ways to improve purchasing, including public financial management (PFM) reforms when needed, and coverage policy design reforms for services that are inclusive of medicines outlined in their benefits packages. Improvements in procurement systems and removal of tariffs on essential medicines in general could result in lower prices and greater availability and alleviate some of the financial burdens on individuals and households.

Potential solutions – condition-specific: While medicines for NCDs and mental health are only one part of the financial protection puzzle for these conditions, they represent relatively easy solutions with high impact. All countries could work towards lowering prices of key drugs for NCD and mental health care through stronger negotiation and regulation. To implement this approach to financial protection, countries must start by identifying which high-priority NCD and mental health medications and conditions are most responsible for high OOP costs in their local context, then target these medicines for price control policies. The Philippines and Ukraine provide several successful examples of price control policies and other mechanisms that enable their health systems to ensure that priority drugs are available free of charge for patients as part of the health benefits package. Emerging evidence suggests that pooled procurement is extraordinarily effective at driving down commodity prices, with examples ranging from cardiovascular drugs in the PAHO region[17] to cancer drugs in India.[18] Pooled procurement is when multiple purchasers create a single purchasing entity that uses their combined funds to acquire commodities in larger quantities, achieving economies of scale and lowering prices for all purchasers. It may be appropriate in some cases to set up schemes to purchase specific commodities that have unique characteristics. For example, cancer drugs and consumables tend to be very expensive, are used by a limited number of facilities, and may undergo a different priority-setting process. This is the case in Ethiopia, for instance. Some countries have had success procuring specific commodities through the ministry of finance, which may be in a better position to negotiate directly with manufacturers to ensure the lowest prices; such a mechanism could complement a pooled procurement arrangement. At the level of benefits package design, another important solution is the elimination, or at least limitation – for example, with an annual household cap – of copayments for persons with any of a pre-specified list of chronic conditions. The justification is that these individuals are particularly vulnerable, like the poor, by virtue of being exposed to an ongoing need for health services including medicines. Chile provides a recent example of legislation eliminating copayments.

Figure 6. Opportunity #3 for financing NCDs and mental health.

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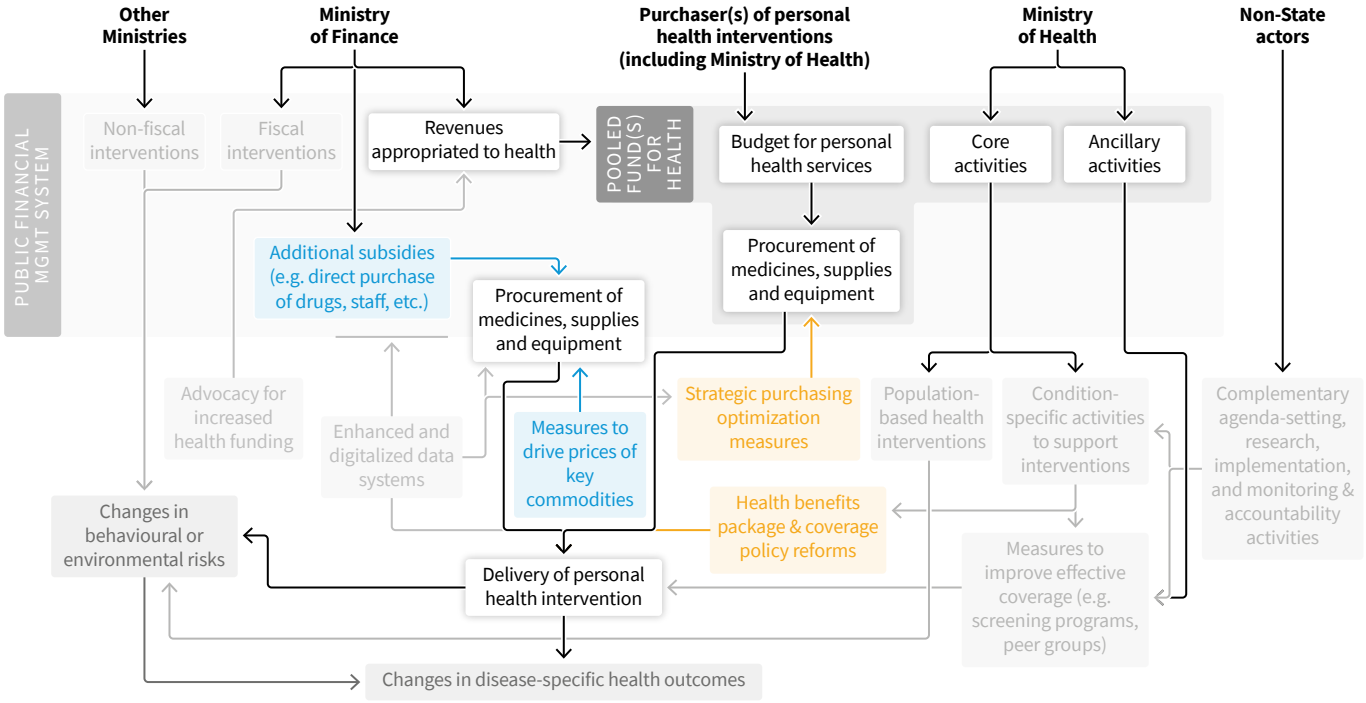

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Opportunity 4 – Enhancing intervention and policy implementation and effectiveness by improving data systems and analytics

The problem: A major theme running through the technical background papers is the lack of high-quality, actionable data to facilitate improved prevention and better case management for NCD and mental health services. There are several interrelated data issues. First, existing approaches to tracking health spending are not optimized to track disease- or intervention-specific spending, limiting the ability to monitor implementation of financing and nonfinancing policies. Second, many countries have weak PFM systems that result in misaligned budget allocations, rigid budget structures, and cumbersome budget execution processes, contributing to inefficiencies in health spending and poor accountability. Third, some countries still do not have reliable civil registration systems with unique identifiers. This constrains the introduction of provider payment mechanisms like capitation, which could be beneficial to better prevention and management of chronic conditions. Fourth, many countries lack electronic medical record systems, and often digital health data systems generally. This impedes quality longitudinal care and coordination across providers – for example, from primary care facilities to hospitals – and possible supportive measures such as performance-based financing measures. Overall, there has been a systematic under-investment in high-quality data as well as ineffective use of existing data in many places; unfortunately, the "costs" of bad data are relatively invisible.

Digital health information systems could enhance the analytical capacities of purchasing agencies where it is most needed – for monitoring the provision of complex care for chronic diseases.

Potential solutions – general: For countries that are underperforming on PFM within the health sector, a top priority will be to strengthen the system. This involves accelerating the transition to program-based budgeting to enable a better alignment of budget resources with sector priorities and greater flexibility in resource use. Streamlining budget execution protocols is also needed to ensure that providers, including for primary care, can access, flexibly manage, and account for outputs. In most countries, financial information management systems also need to be strengthened to monitor provider behavior. Subsequently, these data can be used to provide feedback, facilitate quality improvement initiatives, and inform future budget allocations. Digital health information systems could enhance the analytical capacities of purchasing agencies where it is most needed – for monitoring the provision of complex care for chronic diseases. Many purchasing agencies would also need to expand their workforce to include more data analysts for this work.

Potential solutions – condition-specific: Bespoke data systems for specific health conditions have pros and cons. Experience with global health initiatives suggests that a proliferation of specialized data collection processes and reporting requirements contribute to fragmentation and waste of resources when viewed from a system-wide perspective. Yet disease-specific data included in comprehensive data systems – for example, cancer registries – can be incredibly useful for planning, delivering clinical care, and enabling patients and other stakeholders to hold national systems accountable for policy commitments. The power of having detailed data can be seen in Malawi, which has undertaken several rounds of resource mapping to understand financial flows to different programs as an aid to implementation of the health sector strategic plan and essential health package. The agenda is thus to generate this sort of information from integrated data systems. Countries like Thailand and Colombia regularly capture digital data from their provider payment systems to support financing arrangements that cover specific high-cost NCDs like cancer and end-stage renal disease. Developing and improving existing methods of tracking spending across diseases within the unified national health accounts framework would be valuable. Additionally, a fully digital public system could support expansion of specific services. For example, several digital-based mental health programs have been developed in Bangladesh to extend the reach of mental health services and support distance learning.

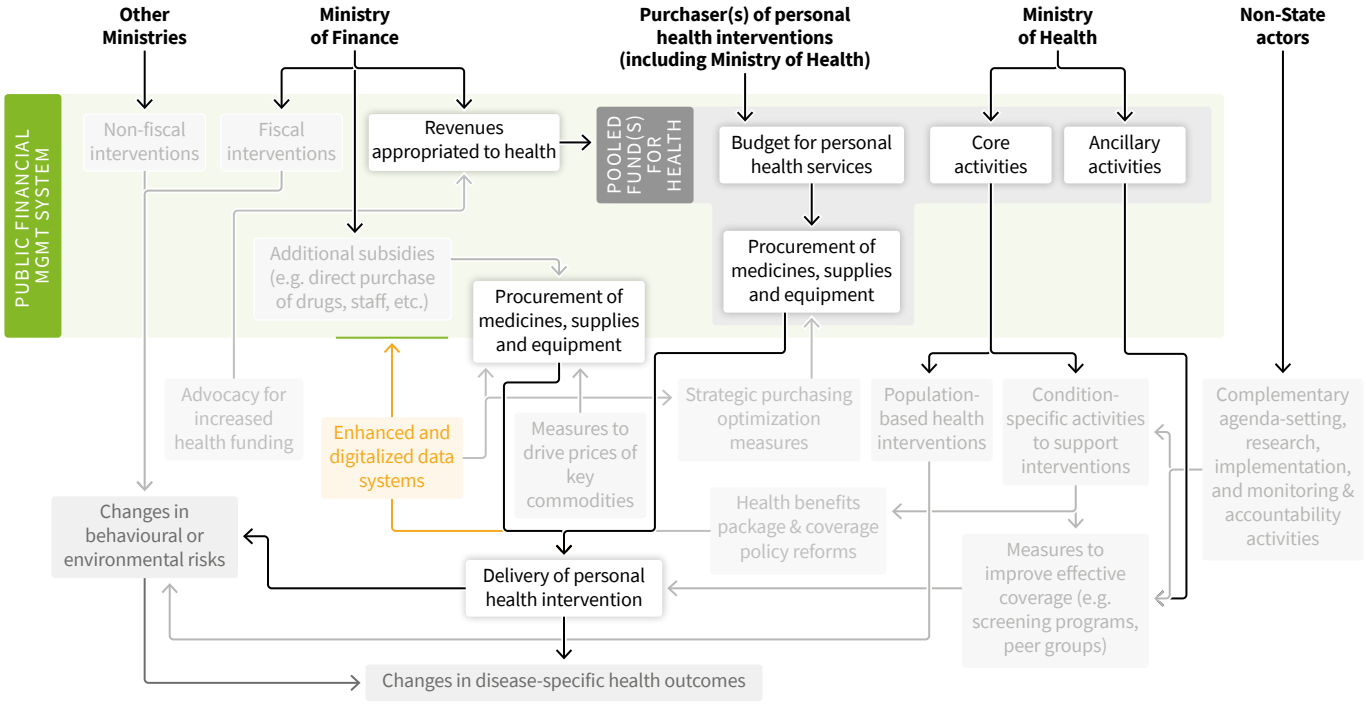

Figure 7. Opportunity #4 for financing NCDs and mental health.

Source: Original figure for this publication.
Note: "Enhanced and digitalized data systems" is conceived as having an impact on the entire PFM system, shown in light grey.

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Opportunity 5 – Increasing the efficiency of spending through innovations in purchasing NCD and mental health services

The problem: Common service delivery models for NCDs and mental health are usually labor-intensive, relatively inefficient, and of suboptimal quality, even in high-income countries. Most health systems are not organized around the need to provide longitudinal care for persons with chronic conditions who may require many episodes of outpatient and inpatient care, often by different providers, over their lifetimes. How to purchase these sorts of services most efficiently, without creating perverse incentives, is an active area of study in countries of all income levels. Population aging and the growing burden of multimorbidity will put pressure on health systems to provide an increasing volume of integrated care for multiple chronic conditions while keeping costs under control. Therefore, "lean" models of integrated, high-quality care that are feasible in countries at all resource levels are needed.

Potential solutions – general: While discussions of service delivery models themselves are outside the scope of the Dialogue, what is relevant is the question of how purchasing arrangements can enable rather than hinder such desired changes in service delivery. Again, purchasing arrangements need to be able to track patients across levels of care and across public vs. private providers, and payment methods should incentivize – or at least not contradict – the desired delivery strategy. Thailand, for example, has made great strides towards strategic purchasing for health services as part of its UHC reforms. What is needed is to overcome knowledge silos between organizations working on integrated service delivery and organizations working on provider payment reforms. Communities of practice and learning networks could be formed to bridge across these sorts of organizations and conduct comparative studies to identify best practices.

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Potential solutions – condition-specific: One issue that is not clear is what sorts of purchasing models are most effective for different types of health conditions. For example, a mix of payment methods may be required for items such as bundles for cancer services that span inpatient and outpatient settings and include many procedures. Different models may also be more effective for chronic care provided – for example, by a primary care provider as compared to a mental health specialist. The Philippines has been experimenting with a mix of provider payment mechanisms to better contain costs for certain services. An emerging area of emphasis in the literature is the scalability of new interventions and implementation approaches beyond the pilot stage.[19]

To take interventions to scale, countries need capable financing systems that include budget mechanisms and PFM capacity for ensuring adequate resources and monitoring for new programs.

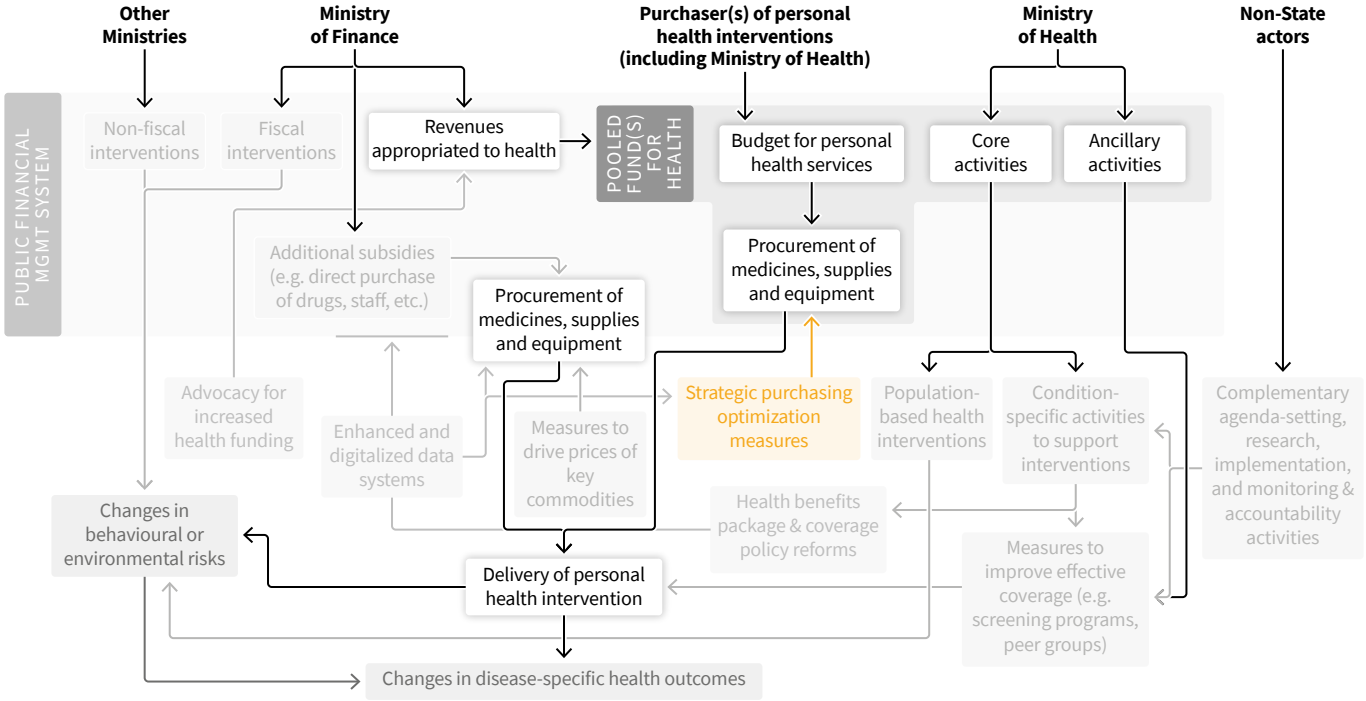

Figure 8. Opportunity #5 for financing NCDs and mental health.

Source: Original figure for this publication.

Part 4: The role of development assistance in addressing NCDs and mental health

Most followers of global health trends do not expect a massive uptick in DAH for NCDs and mental health,[20] and there appears to be little appetite for another global health initiative modeled after existing initiatives for communicable diseases. Yet there are important opportunities to maximize NCD- and mental health-related DAH.

In addition to supporting country projects, DAH should play a key role in supporting collective action. Collective action is defined in this document as groups of countries and organizations working together to address shared challenges.

First, in addition to supporting country projects, DAH should play a key role in supporting collective action. Collective action is defined in this document as groups of countries and organizations working together to address shared challenges. While global action on NCDs and mental health has been slow, there have been numerous examples of successful regional action, such as on pooled procurement of medicines, capacity-building for health technology assessment, and harmonization of food marketing regulations. Sustaining and expanding these regional efforts could complement and enhance country-level projects. Three dimensions of collective action[10] could be targets of DAH:

1. Public goods. Examples include (i) development of new products such as fixed-dose combinations of medicines); (ii) market-shaping efforts to improve access to affordable medicines; (iii) policy and implementation research, including learning networks and other knowledge-sharing platforms; and (iv) innovations in disease measurement and surveillance.
2. Management of cross-border externalities. Examples include (i) control of marketing and distribution of unhealthy products; (ii) control of the tobacco trade across borders; and (iii) strengthening of legal frameworks on firearms control.
3. Promoting leadership and stewardship. Examples include (i) fostering global leadership and advocacy on specific NCD or mental health topics; (ii) collective efforts to counter industry interference in national policy, and (iii) international organizations to support harmonization of economic regulations across countries and to provide ongoing technical assistance to countries, including building local capacity and skills to negotiate on drug prices, for example.

Second, as noted previously, some funders could consider investing in learning networks and other knowledge-sharing platforms, which may also support collective action. The number of country projects on NCDs and mental health has grown substantially in recent years, and it is increasingly important for country efforts to be coordinated and experiences and learnings shared with others.

Third, a lesson learned from interviews with global partners is that it may be necessary to reframe the case for DAH for NCDs and mental health, especially for existing funders. For example, bilaterals and development banks may see the importance of these conditions more clearly when positioned within the broader primary health care agenda. On the other hand, large philanthropies and foundations may be more willing to support projects on specific diseases with unique solutions that align with their interests. For example, a foundation focused on maternal and child health may be willing to support NCD and mental health initiatives that benefit these populations, perhaps using a life course approach.

In preparing for the 2025 High Level Meeting, it would also be helpful for the global community of NCD and mental health experts to identify priorities for DAH and best practices. In the background work for this Dialogue, we propose a series of principles are proposed. When applied by country projects, these would ensure that funding and actions are truly "catalytic" and not unsustainable or open-ended commitments. These principles include:

- Focus on addressing implementation gaps for highly cost-effective interventions and programs, such as those recommended by WHO[21, 22] and the Disease Control Priorities Project.[23]
- Develop standardized approaches for countries to request catalytic funding and provide technical support in preparing proposals.
- Recognize that there is no one-size-fits-all approach to NCDs and mental health, and adequately staff grant review panels to fairly evaluate a diverse range of proposals.
- Respond differently to NCD and mental health funding requests from humanitarian settings, which raise very different issues than pertain in other contexts.
- In the case of the world's poorest countries, remain open to financing NCD and mental health service delivery over the longer term, ideally as part of an integrated strategy for supporting primary health care and pursuing UHC objectives.

Further work after the Dialogue could elaborate on these principles.

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Conclusion

Responding to NCDs and mental health conditions and their risk factors needs to be part of the core business of health systems. Cost-effective intervention and policy options are available for countries at all levels of income, but many countries have struggled to secure adequate financing for NCDs and mental health and to use existing funds efficiently. The COVID-19 pandemic was a further setback to the global and national NCD and mental health agendas, and the macro-fiscal situation in many countries has worsened compared to pre-pandemic trends.

The good news, underscored by the country experiences summarized in this document and the technical background papers, is that there is a range of potential generic and disease-specific solutions to increase and improve financing for NCDs and mental health, even in highly resource-constrained environments. The upcoming Dialogue provides a unique and timely opportunity to further develop and disseminate these ideas in advance of the 2025 High Level Meeting on NCDs. A successful Dialogue will produce, among other outputs, updated technical guidance to countries and to the international community on how to spend wisely to tackle these increasingly important health conditions.

References

1. WHO. 2018. *WHO Global Dialogue on partnerships for sustainable financing of noncommunicable disease (NCD) prevention and control*. Geneva: World Health Organization.
2. Stachteas, P., Manolis Symvoulakis, Apostolos Tsapas, and Emmanouil Smyrnakis . 2022. "The impact of the COVID-19 pandemic on the management of patients with chronic diseases in Primary Health Care." *Population Medicine* 4: 23. doi:10.18332/popmed/152606.
3. Allahqoli, L., Afrooz Mazidimoradi, Hamid Salehiniya, and Ibrahim Alkatout. 2022. "Impact of COVID-19 on cancer screening: A global perspective." *Current Opinion in Supportive and Palliative Care* 16 (3): 102–9. doi: 10.1097/SPC.0000000000000602.
4. Kola, L., Brandon A. Kohrt, Charlotte Hanlon, John A. Naslund, Siham Sikander, Madhumitha Balaji, Corina Benjet et al. 2021. "COVID-19 Mental Health Impact and Responses in Low-income and Middle-income Countries: Reimagining Global Mental Health." *Lancet Psychiatry* 8 (6): 535-50. doi: https://doi.org/10.1016/S2215-0366(21)00025-0.
5. World Bank. 2024. Global Economic Prospects. Washington, DC: World Bank.
6. WHO and World Bank. 2023. *Tracking Universal Health Coverage: 2023 Global Monitoring Report.* Geneva: World Health Organization and Washington, DC: International Bank for Reconstruction and Development/The World Bank.
7. Kurowski, C., Anurag Kumar, Julio Cesar Mieses Ramirez, Martin Schmidt, and Denise V. Silfverberg. 2023. "Health Financing in a Time of Global Shocks: Strong Advance, Early Retreat." Health, Nutrition and Population Discussion Paper. From Double Shock to Double Recovery Series. Washington, DC: World Bank.
8. Global Burden of Disease (GBD) Health Financing Collaborator Network. 2023. "Global investments in pandemic preparedness and COVID-19: development assistance and domestic spending on health between 1990 and 2026." *Lancet Global Health* 11(3): e385–e413. https://doi.org/10.1016/S2214-109X(23)00007-4.
9. GBD 2019 Diseases and Injuries Collaborators. 2020. "Global burden of 369 diseases and injuries in 204 countries and territories, 1990-2019: a systematic analysis for the Global Burden of Disease Study 2019." *Lancet* 396 (10258): 1204–22. https://doi.org/10.1016/S0140-6736(20)30925-9.
10. Watkins, D. A., Gavin Yamey, Marco Schäferhoff, Olusoji Adeyi, George Alleyne, Ala Alwan, Seth Berkley et al. 2018. "Alma-Ata at 40 years: reflections from the Lancet Commission on Investing in Health." Lancet 392 (10156): 1434–60. https://doi.org/10.1016/S0140-6736(18)32389-4.
11. Watkins, D. A., Jinyuan Qi, Yoshito Kawakatsu, Sarah J. Pickersgill, Susan E. Horton, and Dean T. Jamison. 2020. "Resource requirements for essential universal health coverage: a modelling study based on findings from Disease Control Priorities, 3rd edition." *Lancet Global Health* 8 (6): e829–e39. https://doi.org/10.1016/S2214-109X(20)30121-2.
12. NCD Risk Factor Collaboration. 2021. "Worldwide trends in hypertension prevalence and progress in treatment and control from 1990 to 2019: a pooled analysis of 1201 population-representative studies with 104 million participants." *Lancet* 398 (10304): 957–80. https://doi.org/10.1016/S0140-6736(21)01330-1
13. Tangcharoensathien, V., Orana Chandrasiri, Watinee Kunpeuk, Kamolphat Markchang, and Nattanicha Pangkariya. 2019. "Addressing NCDs: Challenges From Industry Market Promotion and Interferences." *International Journal of Health Policy and Management* 8 (5): 256–60. doi: 10.15171/ijhpm.2019.02.

14. WHO Council on the Economics of Health for All. 2023. *Health for All – transforming economies to deliver what matters: final report of the WHO Council on the Economics of Health for All.* Geneva: World Health Organization.

15. Cashin, C., Susan Sparkes, and Danielle Bloom. 2017. *Earmarking for Health: From Theory to Practice*. Geneva: World Health Organization.

16. Brindley, C., Nilmini Wijemunige, Charlotte Dieteren, Judith Bom, Maarten Engel, Bruno Meessen, Igna Bonfrer. 2024. Health seeking behaviours and private sector delivery of care for non-communicable diseases in low- and middle-income countries: a systematic review. *BMC Health Services Research* 24 (1): 127. doi: 10.1186/s12913-023-10464-0.

17. PAHO. 2021. "Essential Medicines for Noncommunicable Diseases available through the PAHO Strategic Fund." Washington, DC: Pan American Health Organization.

18. Pramesh, C. S., Manju Sengar, Sumedha Patankar, Girish Chinnaswamy, Sudeep Gupta, M. Vijayakumar, Sanjeev Sood et al. 2023. "A National Cancer Grid pooled procurement initiative, India." *Bulletin of the World Health Organization* 101 (9): 587–94. doi: 10.2471/BLT.23.289714.

19. SCUBY. 2024. "Scale-up diabetes and hypertension care (SCUBY): scientific journal publications." **https://www.scuby.eu/scientific-output** (accessed 5 June 2024).

20. Fiedler, David P. 2022. "Noncommunicable Diseases and Foreign Policy on Global Health." **https://www.thinkglobalhealth.org/article/noncommunicable-diseases-and-foreign-policy-global-health**.

21. WHO. 2021. *WHO Menu of Cost-effective Interventions for Mental Health*. Geneva: World Health Organization.

22. WHO. 2022. "Updated Appendix 3 of the WHO Global NCD Action Plan 2013–2030." Geneva: World Health Organization.

23. Jamison, D. T., Ala Alwan, Charles N. Mock, Rachel Nugent, David Watkins, Olusoji Adeyi, Shuchi Anand et al. 2018. "Universal Health Coverage and Intersectoral Action for Health: Key Messages from Disease Control Priorities, 3rd edition." *Lancet* 391 (10125): 1108–20. doi:10.1016/S0140-6736(17)32906-9.