WHO global coordination mechanism on the prevention and control of noncommunicable diseases
Working Group on how to realize governments’ commitment to provide financing for NCDs

This discussion paper forms part of the 2014–2015 work plan for the WHO global coordination mechanism on the prevention and control of noncommunicable diseases (GCM/NCD), approved by the Sixty-seventh World Health Assembly,¹ which includes the establishment of a working group to recommend ways and means of encouraging Member States and non-State actors to realize the commitment included in paragraph 45(d) of the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases in September 2011.

The discussion paper, and the feedback received on it, will be considered by the working group at its first meeting in February 2015, as an input into its work and to inform the development of recommendations that it will provide to the WHO Director-General during 2015. While the GCM/NCD work plan requests the working group to “recommend ways and means of encouraging Member States and non-State actors…”, in accordance with WHO’s mandate, all recommendations will be for Member States, including any recommendations regarding the role and contribution of non-State actors.

Feedback on this discussion paper is invited from Member States and other interested parties. Please email feedback to gcmncd@who.int by 6 February 2015.

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1. **Background**

1. In 2011 the United Nations General Assembly adopted the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (resolution A/RES/66/2). In the Political Declaration, Heads of State and Government and representatives of States and Governments committed to explore the provision of adequate, predictable and sustained resources, through domestic, bilateral, regional and multilateral channels, including traditional and voluntary innovative financing mechanisms (paragraph 45(d) of resolution A/RES/66/2) (1).

2. In July 2014, a United Nations General Assembly high-level meeting undertook a comprehensive review and assessment of the progress achieved in the prevention and control of noncommunicable diseases (NCDs), including the commitments made in the Political Declaration. The outcome document of the high-level meeting, adopted by the United Nations General Assembly in resolution 68/300, recognizes that continued and increased efforts are essential in order to realize the commitments included in the Political Declaration. The outcome document acknowledged that “despite some improvements, commitments to promote, establish or support and strengthen, by 2013, multisectoral national policies and plans for the prevention and control of NCDs, and to increase and prioritize budgetary allocations for addressing NCDs, were often not translated into action, owing to a number of factors, including the lack of national capacity” (2).

3. The outcome document furthermore acknowledged that Member States also commit to take the measures to develop and implement national policies and plans, with financial and human resources allocated particularly to addressing NCDs, and to continue to explore the provision of adequate, predictable and sustained resources through domestic, bilateral, regional and multilateral channels, including traditional and voluntary innovative financing mechanisms.

4. WHO estimated the requirements for “best buy” population-based health promotion NCD interventions would have a median cost of less than US$ 0.20 per person per year for low-income and lower middle-income countries and US$ 0.50 for upper middle-income countries. Individual-based, mainly preventive, interventions provided at a primary care level would cost less than US$ 1.00, US$ 1.50 and US$ 2.50 per person per year in low-, lower middle- and upper middle-income countries respectively. The total cost for these “best buy” population- and individual-based interventions in all developing countries would be US$ 11.4 billion annually (3) and represent about 4%, 2% and less than 1% of current annual health expenditure in low-, lower middle- and upper middle-income countries respectively (3).

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2 To “promote, establish or support and strengthen, by 2013, as appropriate, multisectoral national policies and plans for the prevention and control of non-communicable diseases” (paragraph 45).


4 Based on moving from coverage of “best buys” of 5% to a target coverage of 80%; supplementary to existing health systems investments.
5. Resources to support necessary NCD interventions should be ensured by fully utilizing domestic financing, bilateral, multilateral and charitable financing, and innovative financing in an appropriate manner of combination.

6. To prepare for the first meeting of Working Group on how to realize governments’ commitment to provide financing for NCDs in February 2015, three policy briefs have been prepared on the existing landscape for financing NCDs from domestic financing, bilateral, multilateral and charitable financing, and innovative financing. These policy briefs review the existing landscape for financing NCDs from those sources; examine the challenges Member States are facing in financing; and discuss the potential opportunities to address the financing needs for NCDs. This WHO discussion paper is a companion to the three policy briefs, all of which are available on the WHO GCM/NCD website.⁵

2. Situation analysis

2.1 Domestic financing

7. There are limited specific data on domestic NCD funding, but it is known that in spite of commitments to “increase and prioritize budgetary allocations for addressing NCDs” and “establish, by 2013, multi-sectoral national policies and plans for the prevention and control of NCDs”, only 50% of countries had such a policy with an associated budget to allow its implementation by 2013 (2).

8. WHO conducted global surveys in 2010 and 2013 to assess national capacity for the prevention and control of NCDs to gather information about progress made in countries. The surveys show improvement in country capacity for the prevention and control of NCDs over the three years. However, while many countries have components of the necessary national policies and plans in place, they are often not adequately funded or operational. The existence of initiatives to combat NCDs in a growing number of countries provides a strong foundation to extend progress (3).

9. Unfortunately, data on current levels of domestic financing for NCDs are almost non-existent. A growing number of developing countries are including disease-specific subaccounts in their National Health Accounts, which are then included in the WHO National Health Account dataset. However, these generally only include information on HIV/AIDS, malaria, tuberculosis and maternal, child and reproductive health, chiefly because these diseases are prioritized in the health-related Millennium Development Goals. WHO has advised countries to move away from subaccounts for a limited number of diseases and to rather provide a comprehensive overview of the distribution of expenditure across disease categories in line with the 2011 System of Health Accounts.⁶ It is hoped that in future, information on expenditure on diabetes, cardiovascular diseases, cancers and other NCDs will be more readily available.

10. Despite the lack of data on domestic spending on NCD prevention and control, it is possible to comment in broad terms on the key sources of domestic financing in developing

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⁶ Health Accounts – Subaccounts: http://www.who.int/health-accounts/subaccounts/en./
countries. Limited domestic resources, particularly government funding, are available for health services in developing countries.

11. Some developing countries, such as the Philippines and Thailand, have succeeded in having some tobacco tax revenue (and less frequently alcohol tax revenue) earmarked for health services. These revenues are sometimes used for health services or for NCD-specific interventions. Frequently, they are used for health promotion, which may be limited to supporting tobacco control programmes or include other activities such as sports and recreation.

12. In the absence of adequate public funding for health services, out-of-pocket payments are the single largest component of domestic funding in many developing countries, accounting for 48% and 36% of total health expenditure in low- and middle-income countries respectively in 2012. The negative effects of out-of-pocket payments have been well established. Out-of-pocket payments for NCD services impose a particularly heavy financial burden on households, given the long-term nature of NCDs and the frequently high costs associated with diagnosing and treating NCDs. For example, a study of 35 developing countries found significantly higher levels of catastrophic expenditure on health services among individuals with diabetes than otherwise similar individuals without diabetes (4, 5). Where NCD patients are unable to make these out-of-pocket payments, there is evidence that services are not used at all or treatment adherence is compromised. A recent survey of the literature found that patients with cancer and those requiring hospitalization for cardiovascular disease incur the highest levels of catastrophic expenditure from out-of-pocket payments (6).

2.2 Bilateral, multilateral and charitable financing

13. The WHO 2013 progress report on the prevention and control of NCDs stated that 63% of countries report that international donors are an important source of NCD funding (3). However, information and analysis set out here are estimations, since there is no creditor reporting system code to track official development assistance for NCDs.

14. NCDs accounted for 1.23% of all donor assistance for health (DAH) in 2011, or US$ 377 million (7). This is a slight increase from the prior year when NCDs totalled US$ 361 million. While still tiny, NCD donor funding from official sources is growing roughly proportional to overall DAH. The 10-year trend shows almost a tripling of DAH for NCDs, from US$ 129 million in 2000, and a parallel near tripling of overall DAH, from US$ 11 billion to US$ 31 billion.

15. The positive news for NCDs is that donor support has kept pace with the overall increase in DAH; the challenging news is that the absolute amount is still very small. At 1.23% (including funding for tobacco control) (7), NCDs garner the smallest proportion of donor funds of all the major disease areas. HIV/AIDS takes the largest share at 25%, and maternal, newborn and child health receives 20% of all DAH, according to the Institute for Health Metrics and Evaluation report.8

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7 Global Health Expenditure Database: [http://who.int/health-accounts/ghed/en/](http://who.int/health-accounts/ghed/en/).

16. For overall DAH (US$ 31 billion), bilateral donors are the dominant funding source, providing 52%, while the World Bank and WHO each provide 9%. In sharp contrast, in the case of DAH for NCDs (US$ 377 million), bilateral donors provided only 11% in 2011.

17. Multilateral organizations (including the European Union) are collectively the largest source of NCD funding, providing 45% of overall external support in 2011. At 30% of the total, the World Bank is the largest NCD donor, providing about half through concessionary funds and half through market rate lending.

18. Nongovernmental organizations (NGOs) (for example private foundations) as a group provide 27%, which is far more than that of bilateral donors (11%). This category includes organizations that receive substantial funding from the Government of the United States of America, as well as individual charitable giving. The key NGOs include the Bloomberg Philanthropies and the Bill & Melinda Gates Foundation, and they support NCD prevention programmes such as tobacco control. Other non-official sources – charities not based in the United States, private for-profit sources, and research funding – provide funds to developing countries for addressing NCDs, through capacity-building, knowledge-building and service provision.

19. There is reason to believe the actual funds for NCDs may be somewhat higher than official figures indicate. Almost 40% of the total DAH identified is categorized as “unallocable” or “other”, and another 4% is considered “health sector support”. It is likely that some share of each of those categories supports NCD services or the care of patients with NCDs, particularly among donors that do not have a specific budget line for NCDs.

20. Furthermore, some sources of DAH are not included in the databases of the Institute for Health Metrics and Evaluation and the Creditor Reporting System of the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (that is, BRICS11 and Arab States) (7). Although the size and purpose of donor funding from BRICS and other official Development Assistance Committee non-members are not currently known, the BRICS group has officially stated its intention to emphasize NCDs (8). Charitable assistance from charities not based in the United States is also omitted, as is funding from the private, for-profit sector. The private sector is actively funding pilot programmes, advocacy and implementation research on NCDs in low- and middle-income countries (9).

21. Most NCD funding is not regionally targeted. Where there are geographical targets, donor funds for NCDs are concentrated in regions that showed an earlier rise in NCDs and their risks (obesity, tobacco use), such as western and central Asia and Latin America and the Caribbean. Conversely, the vast majority of DAH is directed towards sub-Saharan Africa, which is the only region in the world that still faces a higher burden of communicable disease than noncommunicable disease.

22. The most recent available data are not disaggregated by disease. Earlier disaggregated data showed that the largest segment of donor funding is non-specific “general noncommunicable disease funding”. Of those funding streams with a specific disease or risk factor specified, tobacco received the most funding, followed by obesity,

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9 Ibid.
10 Ibid.
11 BRICS = the emerging economies of Brazil, Russian Federation, India, China and South Africa.
sense organ diseases, diabetes and mental health. Alcohol and kidney disease received the lowest amount of funding (10).

23. NCDs constituted 50% of the global disease burden and just over 1% of donor funding in 2011. NCDs receive a far smaller share of funding than their share in the disease burden. HIV/AIDS represents 4% of global burden of disease and receives the largest share of funds at 33%, while the proportion of donor funding for maternal and child health is closely aligned with the disease burden of 21% (9, 11, 12). The largest gap between burden and funding is for NCDs, though the imbalance is explainable, given the nature of communicable diseases from a welfare economics perspective (that is, services with externalities have a greater call on public funding than do services where the overwhelming bulk of the benefits accrue to the individual being treated).

24. This funding gap seems to result from a perception gap between representatives from developing countries who request technical assistance to address NCDs (demand side) and potential donors (supply side), as these requests from developing countries remain largely unanswered. The current perception among donors seems to be that addressing NCDs is not relevant to addressing the development problems in a developing country. The most frequently asked questions about NCDs that donors have include:

- What is the link between NCDs and poverty in developing countries?
- Are the poorest income quintiles affected the most by NCDs and their risk factors?
- Which interventions are cost-effective and affordable for developing countries?
- Are population-based NCD interventions pro-poor?
- Do population-based NCD interventions contribute to poverty reduction?
- Are technical assistance packages available that strengthen national capacities to address NCDs? Are these packages well tested with demonstrable and measurable impact over a reasonable period of time?
- What is the national funding gap (the cost for a national NCD plan minus available resources to implement the plan)?
- What is the self-enlightened interest of taxpayers in donor countries to support NCD efforts in developing countries?
- When will the OECD Development Assistance Committee have established a creditor reporting system code for NCDs?
- Does support to address NCDs require an increase in global official development assistance?

25. As mentioned earlier (paragraph 4), US$ 11.4 billion is needed annually to carry out NCD “best buy” interventions in all low- and middle-Income countries (13). The current level of DAH for NCDs (US$ 377 million) is 3.3% of this estimated need. Even if donors could provide 10% of the funds needed for the “best buy” by providing a mere US$ 1.14 billion annually for NCDs (a 200% increase over current levels), a gap would still exist. This suggests two points. First, external funders can provide 10% of the funds needed to provide an essential NCD package in all low- and middle-income countries for just 3.7% of current total DAH. Second, even with the greater effort that donors are expected to commit to NCDs, the
majority of funding for NCDs will be required to come from national budgets. At the same time there is an ongoing discussion on whether official development assistance should be used to implement operational programmes, or solely for technical assistance and consequently needs further consideration by Member States.

2.3 Innovative financing

26. Innovative financing approaches can address several key areas surrounding NCDs as new structures can be created similar to those already existing on the health sector landscape to channel additional public funds and increase additional private capital (philanthropic and investment) for scaling up interventions. Innovative financing modalities generally fall into one of three categories: voluntary contributions; levies or taxes; and financial mechanisms. Collectively, between 2000 and 2013, all innovative finance modalities generated US$ 94 billion, US$ 7 billion of which was mobilized in support of global health issues (14), although it is not clear whether this resulted in a net addition of this amount of funding or if this injection led to at least some reallocation of other existing sources away from health.

27. Typical modalities of voluntary contributions have included credit card rounding plans, lotteries and cause-related marketing schemes. Examples include Product (RED) for HIV/AIDS and, within the NCD space, the pink ribbon campaign to raise awareness for breast cancer and raise funds for the Susan G. Komen Foundation.12 Additionally within the NCD area there is the Go Red for Women group, which aims to reduce heart disease in women through awareness-raising campaigns supported by individuals and corporations.13 These mechanisms are designed to bring in additional financial resources and have the added benefit of raising awareness of the issues amongst consumers and employees.

28. In the NCD space, taxes and levies have been under serious consideration both at the national level with the introduction of excise taxes to curb consumption, and also at the international level with initiatives that aim to expand on the idea of the UNITAID airline tax scheme. The proposed Solidarity Tobacco Contribution “micro levy” would skim very small percentages off tobacco product purchases and redirect these monies towards international health-related initiatives (15).

29. With respect to financial mechanisms, there is not one type that emerges as a more popular mechanism than another in addressing health and specifically NCDs, although many of the most successful innovative financing mechanisms globally are examples from the health sector, for example the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the Global Alliance for Vaccines and Immunization (GAVI) (16). Furthermore, there are very few focused specifically on NCDs. The vast majority of the mechanisms designed to address NCDs are funds that are expected to identify additional financing, such as the Battle Against Cancer Investment Trust, which donates a portion of its fees to cancer charities.14 Another example of a fund supporting a specific NCD is the Livestrong Foundation, which collaborates with an investment fund and channels money into the foundation to support its activities in cancer prevention and treatment and patient support (17).

12 Susan G. Komen Foundation: http://ww5.komen.org/.
A small number of investment funds have an approach to seek different health care models for investment globally, for example in primary health and clinics in developing countries. There are few that encourage a more sophisticated role for innovative financing, which might include the development of a mechanism via which the private sector can share risks and rewards or via results-based financing. For example, there are a few investment funds investing in clean cookstove technologies to alleviate respiratory diseases (for example the Spark Fund of the Global Alliance for Clean Cookstoves).¹⁵ NCDs are also often included in funds that seek to invest in health care, hospitals or child care themes, or that have a focus on primary health or services. There also exist a few investment funds for the health sector, but these are in the early days of development and investing. According to J.P. Morgan estimates, of impact investments (for example, investments where investors seek measurable social as well as financial returns) totalling over US$ 46 billion, only US$ 2.76 billion have been invested in the health sector in recent years. Nevertheless, estimates indicate a growing market, and based on their review of existing and forecast market demand J.P. Morgan also estimates that the total market for investment in health is growing and could be as large as US$ 18 billion to US$ 123 billion (18). In fact, health care is behind only food and agriculture as the category that will see the biggest increase in investments in the coming years. Many innovative finance mechanisms involve the private sector as a key partner, and as such it is important to recognize the potential conflicts of interest that may warrant further consideration.

Question 1. Are there other existing or potential sources of funding for NCD prevention and control that are not identified above?

Question 2. What other approaches have proved successful at country level in harnessing greater resources for NCD prevention and control, and what were the key success factors?

Question 3. To what extent should revenues from any new “innovative” revenue-raising modalities be earmarked for NCDs, and if so, how?

Question 4. How can Member States ensure funds bought in from new sources are additional and minimize potentially negative impacts on the allocation of discretionary revenues?

3. Challenges Member States face in allocating and receiving resources for NCDs

3.1 Domestic financing

The most likely reason for slow progress in meeting commitments to devote domestic government funding to NCD prevention and control in developing countries is the very limited growth in real (that is, taking account of inflation) domestic public funding for health services in recent years, particularly in low- and middle-income countries.

Related reasons for why only half of countries have met the goal of having an NCD prevention and control plan with a budget to allow for its implementation are likely to

¹⁵ Global Alliance for Clean Cookstoves – Funding opportunities: [http://www.cleancookstoves.org/funding-opportunities/](http://www.cleancookstoves.org/funding-opportunities/).
include factors such as the rigidity of the public sector financial management environment in some developing countries where historical budgeting practices prevail. Once a pattern of distribution of resources between sectors and between facilities or services is established, it is difficult to break the historical inertia of these patterns. This is particularly the case when overall resourcing is not growing, because directing funds to a new activity or reprioritizing budgets in favour of NCDs requires reducing budgets for other services, although the health expenditures for health care workers and facilities are common for various diseases and health conditions. Resource allocation is a political process with forceful contestation for limited resources.

33. Many NCD advocates focus on arguing for revenue from “sin taxes” on tobacco and alcohol products to be earmarked for prevention and control of NCDs. Traditionally any earmarking of tax revenue has been opposed by ministries of finance, as it reduces their discretion in allocating government resources between the health and other sectors, particularly their ability to respond to changing government priorities. Even when opposition is overcome, earmarking of specific tax revenue may not translate into additional government funding for the health sector. The ministry of finance often simply reduces allocations to the health sector from general revenues, so effectively displacing the earmarked funding. However, ministries of finance appear to respond positively to the public health arguments associated with these taxes, as there is extensive evidence that tobacco tax, and hence price, increases lead to a reduction in tobacco use.

3.2 Bilateral, multilateral and charitable financing

34. Several factors can be held responsible for the bottlenecks in bilateral and multilateral funding for NCDs. Lack of funding can create a cycle with limited and fragmented advocacy and a weak evidence base of proven, cost-effective interventions. This was the picture of global NCDs prior to the commitments made at the United Nations General Assembly high-level meeting in 2011. Other reasons given for donors shying away from making major investments in NCD prevention and control may include (a) the lack of immediate risk to others from NCDs, an argument effectively employed to promote action against infectious diseases; (b) the perception regarding the high cost and possible futility of NCD interventions indicating a weak economic case for intervention; (c) low capacity and preparedness of developing countries to respond to the so-called NCD epidemic; and (d) the sentiment that the responsibility for addressing NCDs lies elsewhere (19).

35. The evidence for proven effective and cost-effective interventions, policies and health systems strengthening actions at the country level is still perceived to be weak. This perception is not completely valid, as studies have demonstrated health improvements are attainable (20). But empirical results from lower-income countries are scarce, as few countries have instituted all of the key policy actions and even fewer have implemented a range of NCD services at scale (21, 22). In addition to lack of funding, a significant barrier to doing so is that many countries are guided by the Millennium Development Goals and therefore are still striving to attain better outcomes for infectious and maternal and child conditions rather than NCDs.

36. Bilateral donors in particular, who are the predominant funders of DAH, have not fully matched their promises with actions. For example, funding from bilateral donors through the United States President’s Emergency Plan For AIDS Relief (PEPFAR) has largely fuelled the enormous increase in capacity and services to respond to the HIV/AIDS epidemic
The case for NCD investments has not yet been coherently made to motivate the major health donors, but the evidence is there.

### 3.3 Innovative financing

Voluntary contribution mechanisms are compelling to increase the visibility of NCD issues on the global agenda, and could draw in additional financing from more traditional sources. However, voluntary contribution schemes do not draw significant additional capital as stand-alone initiatives and are complex to develop, requiring buy-in from a large number of participants to raise significant monies. At the same time, working in public-private partnership with the private sector presents particular risks of strategic, reputation and execution nature that slow the progress of these models.

As regards global solidarity contribution opportunities (for example UNITAID), there is strong support for such initiatives, but one of the challenges remains the ability of developing countries to ensure adequate collection and effective redistribution of such a tax. Furthermore, on some occasions when specific tax revenues are agreed, the earmarking of this revenue may not transpire, and in some cases the ministry of finance may reduce allocations to the health sector from general revenues. To this end, there is learning to be garnered from the ability of several Scandinavian countries to collect and distribute tax revenues.

#### Question 5

Based on experience to date, what are the main challenges or bottlenecks to harnessing greater resources for NCD prevention and control at domestic and international level?

#### Question 6

What further information and analysis would support the case for greater investment in NCD prevention and control?

### 4. Potential options to finance NCDs

The options discussed below should be considered within an overall move towards more integrated funding and delivery of health care services as part of a health systems strengthening approach. Any changes in funding for NCDs, whether domestic, donor related or from innovative financing, should not be seen to be at the expense of other health priorities. Future financing for NCDs will need to be coordinated to ensure both internal coherence, for example donor funding for NCDs is complementary and coordinated with domestic funding, and external coherence, so that it is coordinated and, where possible, integrated with funding for other disease programmes.

#### 4.1 Domestic financing

As a vast majority of NCD funding will need to come from domestic government budgets, consequently, a key strategy would be to demonstrate, at country level, the link between NCDs, economic growth and poverty alleviation, and also to align calls for governments to meet their United Nations General Assembly commitments with advocacy for increased government revenue for NCDs and other health interventions.

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16 UNITAID: [www.unitaid.org](http://www.unitaid.org).
Securing funds for new interventions or to expand existing ones is far more likely when government revenue is increasing. However, overall government revenue and expenditure are relatively low in many developing countries. For example, while government expenditure in advanced economies is on average 45% of gross domestic product (GDP), the average is less than 24% in low-income countries. However, there is a large range within each category of countries, with some low-income countries having government expenditure exceeding 50% of GDP (23), indicating that the level of government revenue and expenditure is not predetermined by a country’s level of economic development. Government revenue in developing countries can be increased by:

- Improving tax compliance and the efficiency of revenue collection. For example, revenue increased in South Africa through improving the management capacity of the revenue authority, changing the organizational culture to one of delivering a service and of zero tolerance for corruption, offering periods of amnesty for tax evaders to encourage compliance, and taking legal steps against those who remained non-compliant (24). In 2012, the Parties to the WHO Framework Convention on Tobacco Control adopted the Protocol to Eliminate Illicit Trade in Tobacco Products, aimed at improving tobacco tax compliance and enforcement. Proper implementation of the protocol could facilitate tax compliance efforts.\(^\text{17}\)

- Increasing tax rates where these are relatively low. Again, a country’s level of economic development does not predetermine its tax rates. For example, while India and Papua New Guinea have per capita GDP levels of less than US$ 2000, they levy amongst the highest taxes and social security contributions on personal income, along with some of the highest-income countries, such as Luxembourg (with a per capita GDP level of US$ 105,509), Denmark (US$ 56,369) and Belgium (US$ 43,593) (23). This not only applies to direct taxes (such as personal income tax) but also indirect taxes (such as value added tax and excise duties). Increasing “sin taxes” on tobacco and alcohol not only reduces consumption of these items, but also can generate considerable revenue, with WHO estimating that if all countries increased tobacco taxes by 50%, tax revenue would increase by US$ 101 billion globally (25). Similarly, an analysis of 42 countries (developing and developed) found that increasing excise duties on alcohol products to at least 40% of the total retail price would increase tax revenue in these countries by US$ 34 billion (26).

- Introducing new taxes (such as financial transactions taxes) (26). There is growing discussion about introducing new “sin taxes” on various foods and beverages (for example on refined, processed foods and sugar sweet beverages) that have harmful health effects.

- Maximizing revenue from the exploitation of mineral and other natural resources, whether through State ownership and operation of these enterprises or increased levels of taxation on private extractive companies (23, 26).

While some of these strategies are a matter of domestic fiscal policy choice, many require supportive global action. For example, there is a need to address tax havens; to deal with tax competition between countries, such as repeatedly reducing corporate tax rates to attract and retain investment in what is termed the “race to the bottom”; to reduce transfer

pricing by multinational corporations; and to improve transparency around payments to developing country governments by extractive companies.

43. A key issue requiring transparent and detailed debate is whether or not to call for earmarking of certain tax revenue (such as “sin taxes”) for NCD interventions. If earmarking is to be pursued, a key lesson from international experience is that often the earmarking relates to only a portion of tobacco (and sometimes alcohol) taxes, and frequently to the additional revenue generated from increasing these taxes or introducing a new element to these taxes (for example the 2% levy on tobacco and alcohol products in Thailand or the 2 paisa health tax per manufactured cigarette in Nepal) (27).

44. A drawback of earmarking certain tax revenue for NCD interventions is that it can contribute to the creation of vertical programmes. On the other hand, a legitimate concern when funds are not earmarked but the focus is instead placed on increasing overall government revenue and ensuring that a fair share is allocated to the health sector is that this will not necessarily translate into improved funding for the prevention and control of NCDs. The “solution” is not necessarily earmarking certain tax revenue for NCDs. Improved services for NCDs, as well as for other diseases and interventions for which additional funds are being advocated (such as HIV/AIDS, tuberculosis, maternal and child health), requires overall health systems strengthening, particularly at the primary care level (28, 29). Strengthening comprehensive primary health care services and addressing the rigidities of public financial management practices is critical and requires commitment by Member States.

45. In particular, there is a growing emphasis on the need to introduce strategic purchasing approaches in developing countries to ensure that the diverse needs of the population are met and that government policy priorities are implemented (30). The concept of strategic purchasing of services involves explicit prioritization in specifying the range of services to be delivered in an integrated way, based on population health needs and cost-effectiveness considerations. Strategic purchasing is likely to be critical in ensuring that adequate government funds are devoted to NCDs. Moreover, it will hold providers of services accountable for the services they deliver, specifically in the case of those delivered to individual clients but less so to more population-based services.

46. It may be helpful to distinguish between population- and individual-level interventions when considering how to optimize domestic funding for NCDs. For population-level interventions, a convincing argument can be constructed for earmarking “sin taxes”. An entity that can facilitate multisectoral engagement and involvement in NCD-related health promotion (such as ThaiHealth) would benefit from an earmarked revenue stream. More generally, however, introducing or increasing taxes on harmful products such as tobacco is an important public health instrument in its own right, whether or not the revenues are earmarked for NCDs or even for the health sector as a whole.

47. Dedicated taxes are not necessarily well suited to funding individual-level services, particularly the diagnosis and treatment of NCDs, but even many preventive interventions for individuals, where these services are provided in an integrated way with other primary health care services. In these instances, very careful consideration must be given to what the perceived benefits of an earmarking approach would be, and earmarking should be compared with the alternative of supporting calls for increases in domestic public funding.
for health services overall and for introducing strategic purchasing arrangements to ensure that needs for NCDs and other health services are met.

48. Member States need to orientate health systems to deliver on NCDs by investing in the system and not NCDs per se. Investing in a health systems approach rather than a vertical approach per NCD is critical.

**Question 7.** What approaches or arguments have proved most successful to date in increasing domestic financing for NCD prevention and control?

### 4.2 Bilateral, multilateral and charitable financing

49. Long-term trends in DAH are promising, and new donors are coming on the global health scene. To continue demonstrating feasibility and create urgency, supportive policy can help overcome an underdeveloped advocacy network and galvanize other actors, including donors. Evidence-based policy proposals are an important stimulus to donor governments, especially when they come from respected institutions in their own countries (31).

50. NCD prevention and control needs to be included in donor country development assistance priorities. For DAH recipient countries, consideration is needed of how to request additional assistance for NCD programmes, including adding NCDs to strategic priorities, both in national development plans and in health sector plans. In the first instance, careful analysis of the disease burden and priorities needs to be built into the diagnostic approach at the start of country-specific needs assessments that lead to the creation of the country plans. Beyond plans, concrete steps are needed to define financial and technical assistance needs that are carefully aligned with the health needs of country populations, country capacity to deliver the NCD “best buys” and other cost-effective services, and the means to measure outcomes. Establishing priorities and a stepwise plan to achieve them will enable recipient countries to prepare a convincing case to donors that their investments will be well placed.

51. Although the amounts are still small, there are signs that funding for diagonal approaches (sometimes called integration) is growing (32). Some donors are supporting new health care delivery methods that focus on community-based or interdisciplinary providers (9). Among these are integrating NCD care with other chronic disease programmes, such as HIV/AIDS and tuberculosis; integrating NCD care with patient- and population-specific programmes, such as maternal and child health; and including NCD care in primary health care delivery. New evidence points towards positive synergies that will improve patient outcomes (32), such as tobacco cessation in tuberculosis programmes to help tuberculosis outcomes.

52. The third International Conference on Financing for Development (Addis Ababa, 13–16 July 2015) will look into the financing of the post-2015 development agenda, including NCDs. It is expected to identify benchmarks and options for NCD financing relevant to the post-2015 goals. This will provide an opportunity for donors to become aware of the criticality of additional funding for NCDs, and the important links between NCD prevention and control and progress on other development goals.

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**Question 8.** What approaches or arguments have proved most successful to date in increasing bilateral, multilateral and charitable funding for NCD prevention and control?

### 4.3 Innovative financing

53. Furthermore, innovative finance as a sector is expected to reach US$ 24 billion per year in 2020, so consequently there is more opportunity to tap into these mechanisms in the support of NCDs, as an additional US$ 18 billion is also expected for global health (14). Health as a sector is only behind food and agriculture as seeing the greatest increase in investment in the coming years.

54. For NCDs it will be important to consider what strategy to adopt going forward for innovative finance: (a) getting existing innovative finance mechanisms to embrace NCDs (that is, how to get the leading group on innovative financing for development to focus also on NCDs, and how to collaborate with the existing organizations in this field, including GAVI, UNITAID and the Global Fund, to include NCDs in the post-2015 agenda); or (b) developing new innovative finance mechanisms for NCDs. No matter which strategy is chosen it will be important that the innovative finance models should contribute to a strengthening of the overall health system, particularly interventions delivered at primary health care level and the provision of a comprehensive package of care that includes NCD-related interventions.

55. Building upon the experience of innovative finance models in the health sector, there are a few models based on the voluntary contribution, taxes or levies, and financial mechanisms that could be considered to support financing of NCDs. It is the case that some innovative mechanisms already exist or are being introduced to fund overall expansion of health coverage mechanisms in certain countries. These mechanisms would seek to attract new fund flows, raise the interest of donors and investors in areas relevant to NCDs, and cover different types of investment opportunities, with different roles for Member States, and different levels of design and implementation complexity. There are many models to explore to test what will best fit the demand from donors and investors (public, charitable and investment), the needs of the NCD sector and how Member States could be involved in this space.

**Question 9.** What innovative financing approaches have proved most successful to date in increasing additional funding for NCD prevention and control?

**Question 10.** Are there other innovative financing approaches that should be considered to help to increase net funding for NCD prevention and control at country and global level?

**Question 11.** What are the recommendations to Heads of State and Government to ensure that their 2011 commitment is realized before the third high-level meeting on NCDs in 2018?

### 5. Conclusions and next steps

56. There is considerable opportunity for increased commitments for the prevention and control of NCDs through avenues described in this paper, namely domestic financing, bilateral, multilateral and charitable financing, and innovative financing modalities.
Fortunately, there are clear lessons from experience to date, with much more room to move forward. Many experiences in Member States are transferable and they can support each other in a range of ways to make greater progress.

57. Feedback on this discussion paper is invited from Member States and other interested parties, including providing examples of progress being made in the areas identified in the 2011 Political Declaration. Feedback should be received by 6 February 2015.

References


About the WHO global coordination mechanism on noncommunicable diseases (GCM/NCD)

Terms of reference for the establishment of the WHO global coordination mechanism on the prevention and control of noncommunicable diseases were endorsed by the Sixty-seventh World Health Assembly in May 2014. The scope and purpose of the WHO GCM/NCD are to facilitate and enhance coordination of activities, multistakeholder engagement and action across sectors in order to contribute to the implementation of the WHO Global NCD Action Plan 2013–2020.

The 2014–2015 work plan of the GCM/NCD has five objectives; under objective 5, a working group is being established to recommend ways and means of encouraging Member States and non-State actors to realize the commitment included in paragraph 45(d) of the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases.

For further information on the GCM-NCD, see http://www.who.int/nmh/ncd-coordination-mechanism/en/.

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