WHO Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases

Final report and recommendations from the Working Group on 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 United Nations General Assembly on the Prevention and Control of Non-communicable Diseases.
This report is the outcome of the Working Group convened by the WHO Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases (GCM/NCD), based on objective 5, action 5.1 of the 2014–2015 GCM/NCD work plan, to “establish a Working Group in 2014 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 United Nations General Assembly on the Prevention and Control of Non-communicable Diseases”. The Working Group was tasked with providing recommendations to the WHO Director-General on ways and means of encouraging countries to realize their commitments to “explore the provision of adequate, predictable and sustained resources, through domestic, bilateral, regional and multilateral channels, including traditional and voluntary innovative financing mechanisms”.

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Key messages and recommendations

The following key messages are the result of the rich discussions among the Working Group members, and have formed the basis for the recommendations contained in this report.

Time for action

Noncommunicable diseases (NCDs) can impede sustainable development because of their negative impact on macroeconomic productivity, national incomes, health care budgets, household income and impoverishment.

The cost of inaction far exceeds the cost of action. The return on investment for NCD spending is promising and governments should set national spending targets for annual investment in health including for NCDs. There is compelling evidence of the economic impact of NCDs and the cost of inaction. Sixteen million people die prematurely each year from NCDs, of whom 82% are in developing countries. The probability of dying prematurely from an NCD is 4 times higher for people living in developing countries than in developed countries. Macroeconomic simulations predict that over the period 2011–2025, the cumulative global economic losses due to the four main NCDs will surpass US$ 51 trillion. While the cost of inaction associated with the four major NCDs in low- and middle-income countries alone is projected to be more than US$ 7 trillion between 2011 and 2025, the cost of action in these same developing countries is estimated at US$ 170 billion in the same period. The return on investment for NCD spending is promising, and governments should set national spending targets for annual investment in NCD responses.

The actions will vary across countries of different income and development levels, but bolder measures are needed for all countries to mobilize financial and technical resources from an increased number of actors to support national NCD responses.

What governments must do

Governments must fulfil the commitments they made in 2015, building on their commitments made in 2011 and 2014, to increase health expenditure on the prevention and control of major NCDs, with a view to attaining national NCD targets for 2025 and 2030, based on the nine global, voluntary targets for NCDs and the NCD-related targets included in the Sustainable Developmental Goals. NCD prevention, treatment, and care should be part of universal health coverage packages and should be given priority in the overall health budget according to the burden of NCD diseases.

Governments need to avail themselves of “blended” financing streams, with particular reliance on domestic financing through multiple mechanisms.

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2 The global economic burden of non-communicable diseases. World Economic Forum and Harvard School of Public Health; 2011.

Governments need to ensure greater efficiency in overall domestic health spending. Increased resources for health, particularly for NCDs, through official development assistance (ODA), economic growth, and engagement with the private sector will enable countries undergoing epidemiological and economic transitions to increase spending on NCD prevention and control, bridging the gap between resource needs and current outlays.

Building on their commitments made in 2015, governments must strengthen the regulation of the marketing of food and non-alcoholic beverages to children and incentivize the private sector to invest in areas critical to addressing NCDs, producing and promoting more food products consistent with a healthy diet, reducing the use of salt in the food industry, and contributing to efforts to improve access to and affordability of medicines for NCDs.

Governments must establish effective and transparent intersectoral governance structures. This is key to managing intragovernmental incentive conflicts, protecting against industry interference, promoting policy coherence, improving information sharing and allocation of resources, identifying synergies, nurturing co-benefit analysis, and enhancing planning and financing modalities. These are the rationale for Article 5.2(a) of the World Health Organization (WHO) Framework Convention on Tobacco Control, and a core component of the recently launched United Nations Development Programme (UNDP)-WHO joint programme on Catalysing Multisectoral Action for NCDs.

**What international development agencies should do**

Building on their call in 2014 for the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee to track ODA for NCDs, and recognizing that an important use of that ODA would be to catalyse additional resources from other sources to increase health expenditure on the prevention and control of NCDs, international development agencies must grasp the opportunity presented by the 2030 Agenda for Sustainable Development to mobilize domestic support towards the fulfilment of ODA commitments for NCDs, including through raising public awareness, providing data and demonstrating tangible results.

**Next steps**

There are significant information and knowledge gaps at the global, regional and country levels that impede access to adequate, predictable and sustained financing for NCDs, implementation of best practices for efficient use of resources, and advancement of universal health coverage, including for NCDs.

In line with addressing these key messages and in an effort to support governments in implementing the following recommendations, the Working Group also addressed the need for a framework that sets out a stepwise process to enable countries to identify the best context-specific options for financing national NCD responses and to share experiences that strengthen national capacity to use the available tools (Part II and annexes of this report).

The next steps could notably include the development of a comprehensive investment framework for NCDs and the creation of a global investor platform (or “marketplace”) to demonstrate demand and

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4 To engage private sector entities as partners in implementing ambitious national Sustainable Development Goal responses, and to strengthen regulatory frameworks to better align private sector incentives with public goals.


support and to further disseminate knowledge and share information based on scientific evidence and best practices regarding implementation through the GCM/NCD web-based platform, through webinars or through establishing communities of practice.  

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<tr>
<th>Recommendations</th>
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<tr>
<td><strong>Recommendation 1</strong></td>
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<td>Mobilize and allocate significant resources to attain the NCD-related targets included in the Sustainable Development Goals by 2030, and the nine global voluntary NCD targets included in the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 by 2025.</td>
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<tr>
<td><strong>Recommendation 2</strong></td>
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<tr>
<td>Effectively and efficiently utilize and expand domestic public resources to implement national NCD responses, including by making greater use of revenue from tobacco and other health-related taxes to achieve national health objectives.</td>
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<tr>
<td><strong>Recommendation 3</strong></td>
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<td>Complement domestic resources for NCDs with official development assistance (ODA) and catalyse additional resources from other sources to increase health expenditure on the prevention and control of NCDs, consistent with country priorities.</td>
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<tr>
<td><strong>Recommendation 4</strong></td>
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<td>Promote and incentivize financing and engagement from the private sector to address NCDs, consistent with country priorities on NCDs.</td>
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<td><strong>Recommendation 5</strong></td>
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<td>Enhance policy coherence across sectors in order to ensure that the expected outcomes of national NCD policy are achieved, including by assessing the health impact of policies beyond the health sector.</td>
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This report is divided into four parts: an introduction with background and justification for the recommendations, Part I on the recommendations and Part II on the approaches and tools for assessment and implementation of national NCD financing options, and a conclusion.

The recommendations and tools are the result of three meetings of the working group in 2015, including consultations with stakeholders, policy briefs commissioned by the GCM/NCD Secretariat, and technical inputs from WHO. All these inputs are documented at the WHOGCM/NCD web page: [http://who.int/global-coordination-mechanism/working-groups/wg-5-1-financing/en/](http://who.int/global-coordination-mechanism/working-groups/wg-5-1-financing/en/).

The report also identifies a set of important knowledge gaps to be addressed to create an enabling environment and next steps for multiple stakeholders. Readers are encouraged to refer to the three policy briefs prepared for the Working Group for further background information.

The Working Group will submit this report to the WHO Director-General in accordance with its mandate.

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Introduction

1. Background

In September 2011, Heads of State and Government acknowledged that noncommunicable diseases (NCDs), which include four main diseases (cardiovascular diseases, diabetes, cancer and respiratory diseases) and their four main risk factors (tobacco, alcohol, unhealthy diet and physical inactivity) constitute one of the major challenges for development in the 21st century – an issue that the Millennium Development Goals did not address. In the meeting’s Political Declaration on NCDs, paragraph 45(d), Heads of State and Government 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”, and also committed to take measures to develop and implement national policies and plans, with financial and human resources allocated particularly to addressing NCDs.

In 2013, the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 was adopted in the World Health Assembly. The Global Action Plan on NCDs provides a roadmap and a menu of policy options for all Member States and other stakeholders to take coordinated and coherent action, at all levels, local to global, to attain the nine voluntary global targets, including that of a 25% relative reduction in premature mortality from cardiovascular diseases, cancer, diabetes and chronic respiratory diseases by 2025.

In July 2014, ministers of foreign affairs and health welcomed the increase in the number of countries that have an operational national NCD policy with a budget for implementation, from 32% of countries in 2010 to 50% of countries in 2013. However, they also noted that, despite these improvements, commitments were often not translated into action in developing countries, owing to a lack of national capacity. The United Nations High-level Meeting on NCDs agreed on a set of time-bound commitments, including by 2015 setting national targets and developing national multisectoral plans and policies taking into account the WHO Global Action Plan on NCDs, and by 2016 reducing exposure to risk factors and enabling health systems to respond.

Four years after the United Nations Political Declaration on NCDs, in September 2015, world leaders adopted the 2030 Agenda for Sustainable Development, including the Sustainable Development Goals, which include targets by 2030 to reduce by one third premature mortality from NCDs through prevention and treatment, and to strengthen the implementation of the WHO Framework Convention on Tobacco Control (FCTC) in all countries (Box 1).

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10 Resolutions adopted by the United Nations General Assembly and the WHO World Health Assembly that are relevant to the work of the WHO GCM/NCD Working Group on Financing for NCDs are presented in Annex 1 of this report.


12 “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.” See paragraph 14 of resolution A/RES/68/300.
Heads of State and Government also committed to develop ambitious national responses to the Sustainable Development Goal targets as soon as possible. This clear roadmap for national integrated multisectoral and multistakeholder responses to the NCD-related Sustainable Development Goal targets highlights the need to consider financing options based on the increased mobilization and effective use of domestic resources, public and private, including bilateral, multilateral and innovative financing, over the next 15 years, as set out in the Addis Ababa Action Agenda adopted by world leaders in July 2015.

In spite of the repeated high-level affirmations, commitments have not been translated into actions. A significant number of countries show very poor achievement on the progress indicators of the WHO NCD Progress Monitor, which tracks the extent to which 194 countries are implementing their commitments to develop national responses to the global burden of NCDs. Of those countries, 14 are not achieving a single progress indicator, and a further 20 are only achieving one of the indicators. This underscores the need for countries to scale up actions in order to make real and sustained investments in the most promising and proven interventions for NCD prevention and control.

Box 1a. NCD-related targets for 2030 included in Sustainable Development Goals

- by 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being (target 3.4);
- strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol (target 3.5);
- achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all (target 3.8);
- strengthen the implementation of the WHO Framework Convention on Tobacco Control in all countries (target 3.a);
- support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all (target 3.b);

Box 1b. Other relevant targets for NCDs included in Sustainable Development Goals

- by 2020, halve the number of global deaths and injuries from road traffic accidents (target 3.6);
- by 2030, end hunger and ensure access by all people, in particular the poor and people in vulnerable situations, including infants, to safe, nutritious and sufficient food all year round (target 2.1);
- by 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on

13 Resolution A/RES/69/313.

14 The NCD Progress Monitor provides a snapshot of some of the achievements and challenges faced by both developed and developing countries as they strive to reach globally agreed targets to combat cancer, diabetes, and heart and lung disease. It uses the 10 indicators and their sub-indicators on which WHO will base its report on progress at the 2018 High-level Meeting on NCDs at the United Nations General Assembly. http://www.who.int/nmh/publications/ncd-progress-monitor-2015/en/.

stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons (target 2.2);

- protect labour rights and promote safe and secure working environments for all workers, including migrant workers, in particular women migrants, and those in precarious employment (target 8.8);

- implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable (target 1.3).

2. **Context and purpose of the Working Group**

The Sixty-seventh World Health Assembly agreed to establish, under the WHO Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases (GCM/NCD), 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 United Nations General Assembly on the Prevention and Control of Non-communicable Diseases.

The members of the Working Group are drawn from a roster of experts nominated by Member States, appointed by the WHO Director-General and co-chaired by representatives from two Member States, one from a developed country and one from a developing country, appointed in consultation with Member States by the WHO Director-General. The Working Group’s terms of reference, membership, meeting papers and background documents are available on the WHO website.

Much of the experience and evidence that informed the Working Group’s deliberations is contained in the background documents, and these form important references for this report:

Part I on the recommendations is more oriented for high-level policy makers’ whereas Part II on approaches and tools for assessments and implementation of national NCD financing options cover, with more granularity and detail aspects of a steps-wise approach to support implementation of NCD financing, which can be useful for Ministries of Health.

3. **Overview of the shifting financial landscape and the need for blended financing for NCDs**

3.1 **Momentum for integrated approaches for addressing NCDs**

3.1.1 Promoting and strengthening policy coherence

Fragmentation of programmatic, policy and financing priorities in health is a source of both inequities and inefficiencies in international development agendas. The Addis Ababa Action Agenda addresses policy incoherence through promoting and strengthening coherence and consistency of multilateral financial, investment, trade, development and environment policies, institutions and platforms, and increasing cooperation between major international institutions, while respecting mandates and governance structures.\(^{18}\)

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\(^{17}\) [http://www.who.int/global-coordination-mechanism/working-groups/en/](http://www.who.int/global-coordination-mechanism/working-groups/en/)

\(^{18}\) Resolution A/RES/69/313.
A whole-of-government approach to reducing NCDs is needed. NCD goals need to be part of development and sectoral planning processes, with coordination across multiple ministries and partner agencies, such as the United Nations. Adherence to the timelines for achieving the NCD-related Sustainable Development Goal targets will encourage cooperation across sectors. A multisectoral commission is a useful mechanism for coordination and policy alignment. Governments can be supported by United Nations processes to conduct a multisectoral policy review to identify where policies are working at cross-purposes.

3.1.2 Accelerating equitable and sustained NCD responses in the context of universal health coverage

NCD prevention, treatment, and care should be part of universal health coverage packages supported mainly by public funding. NCDs place substantial economic burden on patients, their households and their caregivers across all socioeconomic strata, but in particular for the poorest. Lack of access to and availability of affordable quality, safe and effective medicines, health technologies and health care services, including prevention, timely diagnosis and care, increase preventable impairments and compound the mortality rates. Therefore, it is desirable to increase the public revenue share in health financing, measured as general government health expenditure as a percentage of total health expenditure. In April 2001, Heads of State of African Union countries met and pledged to set a target of allocating at least 15% of their annual budget to improve the health sector through the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases. At the same time, they urged donor countries to “fulfil the yet to be met target of 0.7% of their GNP as official development assistance (ODA) to developing countries”. This drew attention to the shortage of resources necessary to improve health in low-income settings and also the importance of an increase in the proportion of total government expenditure allocated to health. Ministers of health and ministers of finance can enhance governance of the official development funds that are flowing into the country for health. Many of these funds do not flow through the government. External partners are frequently reluctant to report to the recipient government how these funds are spent, so it is difficult to know if they are being spent efficiently and if they are being spent according to national priorities. Countries will determine how they will progress along the three dimensions of universal health coverage: population coverage for health, prepaid health services, and proportion of needed interventions covered, and how financing of NCDs will be covered.

19 http://www.who.int/universal_health_coverage/universal-health-coverage-access-pr-20141212.pdf?ua=1.
3.2 The strong case for increased resources to implement national NCD responses

3.2.1 High return on investment in NCDs

The cost of inaction far exceeds the cost of action: US$ 7 trillion versus US$ 170 billion

While the cost of inaction in low- and middle-income countries is estimated at US$ 7 trillion between 2011 and 2025, the cost of action in these same developing countries is estimated at US$ 170 billion between 2011 and 2025.

A number of multisectoral and multistakeholder policy options and cost-effective interventions for addressing NCDs in low- and middle-income countries are included in the WHO Global Action Plan on NCDs 2013–2020, Appendix 3. The potential to address the huge impact felt in all countries by NCDs is clearly achievable, as demonstrated by the countries where real progress has been made, according to preliminary data from the WHO NCD Progress Monitor. When selecting interventions for the prevention and control of NCDs, countries should consider effectiveness, cost-effectiveness, affordability, implementation capacity, feasibility, national circumstances, and impact on health equity of interventions.

In its Global Action Plan on NCDs, approved by the World Health Assembly in 2013, WHO estimated that the “best buy” population-based NCD interventions would have a median average 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. The total cost for these “best buy” population- and individual-based interventions in all developing countries would be US$ 11.4 billion annually and would represent about 4%, 2% and less than 1% of current annual health expenditure in low-, lower middle- and upper middle-income countries respectively.

The return on investment for NCD spending is promising

A recent analysis of the return on investment for NCD spending indicates that Barbados is spending US$ 32 million, or approximately US$ 110 per capita, per year on cardiovascular disease and

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23 See paragraph 45(d) of the 2011 United Nations Political Declaration on NCDs, by which 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”. http://www.un.org/ga/search/view_doc.asp?symbol=A/66/L.1.


26 Based on moving from coverage of “best buys” of 5% to a target coverage of 80%; supplementary to existing health systems investments.

On top of those costs, the national economy is losing US$ 72 million per year due to missed workdays, poor productivity, reduced workforce participation and the costs to business of replacing workers from cardiovascular disease and diabetes alone. Together these costs represent around 2.6% of the projected gross domestic product (GDP) for Barbados in 2015. The return on investment between 2016 and 2030 from scaling up prevention interventions and diagnostic and treatment coverage is 3.9 (6.3 with health returns included), or a total of about US$ 300 million in increased productivity over the 15-year period, representing around 1% of annual national GDP.

3.2.2 Economic growth benefits of NCD prevention and control

The epidemiological, demographic, and economic transitions experienced by many countries, developed and developing, both necessitate and create avenues for a shift in health care emphasis. Health investments that have been and still are being made to reduce maternal and child deaths and infectious diseases are producing two dividends: stronger and more integrated health systems that can more efficiently deliver a broader package of services; and decreased health burdens from traditional sources. Both suggest that increased health spending can be efficiently and effectively allocated towards NCDs in countries undergoing these changes. Additionally, in most countries, economic growth is expected to generate “new” funds that could be available for NCD prevention and control. This growth will produce almost US$ 1 trillion in additional GDP in low-income countries and almost US$ 9 trillion in lower middle-income countries. Economic development, along with GDP growth, is historically seen as a function of improved population health status. However, in low-income countries not yet undergoing epidemiological transition or experiencing strong economic growth, additional external resources are needed to enable countries to implement NCD interventions, following the principles of equity and local priority setting.

3.3 Importance of a “blended” stream of financing for NCDs

In pursuit of achieving the nine voluntary global targets on NCDs and national NCD strategies, as well as the Sustainable Development Goals, countries will turn to multiple financing sources, depending on their disease burdens and epidemiological trends, fiscal capacity, existing donor relationships, role of the private sector and other factors. The result will be a “blended” stream of financing for new NCD programmes, tailored to country performance as much as to needs. Progress on the WHO Global Monitoring Framework for Noncommunicable Diseases, supported by the NCD Progress Monitor and the Sustainable Development Goal indicators, gives countries very clear health performance metrics to offer donors and other financers of NCD programmes, which will need to be combined with economic performance measures and considered in the light of available financing mechanisms and donor interests.

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30 http://www.who.int/nmh/media/ncd-progress-monitor/en/
An example of a blended stream of financing consists of a combination of the elements shown in Figure 1 (from Annex 7). Some elements are further described in the ensuing subsections.  

**Figure 1. Elements of a blended stream of financing**

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### 3.3.1 Domestic financing

There are limited data on domestic NCD funding, but evidence shows that despite commitments to “increase and prioritize budgetary allocations for addressing NCDs” and “establish, by 2013, multisectoral 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. While government expenditure in advanced economies is on average 45% of GDP, the average is less than 24% in low-income countries. Out-of-pocket payments are the single largest component of domestic health 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.

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31 Annex 7 of this report further describes the characteristics of these different financing options and highlights which are appropriate for different levels of country capacity, and Annex 3 provides examples of how countries are financing NCDs.


WHO is supporting countries in preparing comprehensive overviews of the distribution of expenditure across disease categories in line with the 2011 System of Health Accounts.\(^{34}\) Expenditure analysis from an initial set of eight low-income countries shows that 33% of spending is from the public sector, 54% from household payments, and 13% from external sources, with an average per capita spending on NCDs of US$ 1.90.\(^{35}\)

### 3.3.2 Bilateral and multilateral funding

NCDs garner the smallest proportion of donor funds of all the major disease areas, and a far smaller share of funding than their share in the disease burden. NCDs constituted 50% of the global disease burden and less than 2% of donor assistance for health in 2014.\(^{36}\) HIV/AIDS represents 4% of the 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%.

The WHO 2014 *Global status report on the prevention and control of NCDs* stated that 64% of countries report that international donors are an important source of NCD funding.\(^{37}\) However, information and analysis set out here are estimates, as there is no creditor reporting system code to track ODA for NCDs, unlike for many other disease categories, making it very difficult to track and analyse aid expenditure on NCDs.

### 3.3.3 Innovative financing

Innovative financing initiatives, which can be implemented at the global or country level and channelled towards national NCD responses, generally fall into one of three categories:

- **Voluntary contributions.** Voluntary contributions have included credit card rounding plans, lotteries and cause-related marketing schemes.

- **Compulsory levies or taxes.** These exist both at the national level with the introduction of excise taxes to curb consumption of unhealthy products, and also at the international level with initiatives that aim to expand on the idea of the UNITAID airline tax scheme.

- **Financial mechanisms.** This category may include global institutional mechanisms, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the GAVI Alliance, or local institutional arrangements, such as microfinance. It can also include international borrowing, and public–private financing arrangements, such as the Global Financing Facility. There are no innovative financing mechanisms currently focused specifically on NCDs.

Collectively, between 2000 and 2013, all innovative financing initiatives generated US$ 94 billion, US$ 7 billion of which was mobilized in support of global health issues,\(^{38}\) though 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.

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\(^{34}\) Health Accounts – Subaccounts: [http://www.who.int/health-accounts/subaccounts/en/](http://www.who.int/health-accounts/subaccounts/en/).


\(^{36}\) A large share of this funding is for tobacco control and is allocated to upper middle-income countries. IHME, Financing Global Health Database, 2014, see [http://www.who.int/nmh/ncd-coordination-mechanism/Policybrief5.2.docx.pdf?ua=1](http://www.who.int/nmh/ncd-coordination-mechanism/Policybrief5.2.docx.pdf?ua=1), as well as Financing global health: [http://vizhub.healthdata.org/fgh/](http://vizhub.healthdata.org/fgh/).

\(^{37}\) [http://apps.who.int/iris/bitstream/10665/148114/1/9789241564854_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/148114/1/9789241564854_eng.pdf?ua=1).

\(^{38}\) Innovative financing for development: scalable business models that produce economic, social, and environmental outcomes. Dalberg; 2014.
3.3.4 Development financing: NCD-related loans

As the 2030 Agenda for Sustainable Development gains traction in development financing, the United Nations must broaden its view of resource-leveraging options for NCD prevention and control. Emphases for financing relate to greater domestic allocations for health and development, more structured and consistent partnership with the private sector, and a greater reliance on loan mechanisms versus more traditional forms of ODA. The development banks have been focused on Millennium Development Goal-related financing, but a transition has started towards Sustainable Development Goal-related financing, catalysing latent demand from borrowing countries. It was estimated in early 2015 that there were 22 NCD-inclusive loans being administered by the World Bank, and new loans have been negotiated over the intervening period, for example a loan worth over US$ 300 million for Argentina. Regional banks also, notably the Inter-American Development Bank, have a number of pre-existing and newly negotiated loans on NCDs (Trinidad and Tobago, for example, with a loan of around US$ 110 million).

Building on the logic that NCD prevention and control result in development outcomes, while engaging concepts such as inequity reduction and whole-of-society and whole-of-government responses, the United Nations system should be better positioned to influence and technically support Member States during the negotiations and indeed during the execution of loan agreements. United Nations actors should emphasize the importance of outlining the efficient targeting and use of resources in national responses, building on bespoke investment cases as appropriate. Other features of engagement would concern human rights-based programming, equity reduction and inclusive governance in loan design, programme implementation and monitoring. Partnerships with civil society would be facilitated in support of these roles.

Greater engagement with the development banks is imperative for the United Nations system to ensure a greater and more efficient resource flow towards the design, implementation and monitoring of national NCD prevention and control responses. United Nations country teams and global and regional interagency task forces have a major role to play in this regard.

3.3.5 Engagement with the private sector

Using public finance to leverage private sources is a tool that can be useful for creating mutual benefits. Blending, which in this case combines grants with loans or equity from public and private financiers, is considered as one of these vehicles, along with public–private partnerships and other tools for leveraging additional resources. The private sector’s experience and know-how are just as important to attract as its funds. Public–private partnerships for the purpose of delivering a project or in-kind services traditionally provided by the public sector can be an effective means of making the supply of NCD-related public goods and NCD services to least developed populations more reliable and affordable, while complementing government resources. Public–private partnerships can provide innovative solutions in many NCD areas, but there is a tendency in current public–private partnerships to focus on short-term returns, whereas many NCD interventions will have long-term returns on investment.

Part I

4. Recommendations

The recommendations from the Working Group are based on their experience as high-level experts nominated by the Member States and emphasize the key actions that governments can take in realizing their commitment to “explore the provision of adequate, predictable and sustained resources, through domestic, bilateral, regional and multilateral channels, including traditional and voluntary innovative financing mechanisms.”

These recommendations apply to all areas included in paragraph 45(d) of the United Nations Political Declaration on NCDs.

4.1 Recommendation 1

Mobilize and allocate significant resources to attain the NCD-related targets included in the Sustainable Development Goals by 2030, and the nine global voluntary NCD targets included in the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2025.

Building on their commitments made in 2011 and 2014 to increase budgetary allocations for addressing NCDs, governments must fulfil the commitment they made in 2015 to increase health expenditure on the prevention and control of major NCDs, with a view to attaining national NCD targets for 2025 and 2030 (which will contribute to the attainment of the nine NCD targets for 2025 and the six NCD-related Sustainable Development Goal targets for 2030).

Action steps

Heads of State and Government may select and undertake actions set out below:

- accelerate progress on the commitment made in July 2014 to raise awareness about the national public health burden caused by NCDs and the relationship between NCDs, poverty and socioeconomic development;\(^{41}\)
- develop and implement integrated multisectoral national policies and plans, with financial and human resources allocated particularly to addressing NCDs, and continue to explore sustainable financing mechanisms from a variety of sources;\(^{42}\)
- track expenditure on NCDs across all government departments, include NCDs in National Health Accounts\(^{43}\) and set national spending targets for annual investment in NCD responses;\(^{44}\)

\(^{40}\) To develop ambitious national responses to the Sustainable Development Goals.

\(^{41}\) See paragraph 30(a)(iv) of resolution A/RES/68/300.

\(^{42}\) See paragraph 30(a)(iv) of resolution A/RES/68/300.

\(^{43}\) See Annex 4 of the report for examples of National Health Accounts.

• develop and better articulate the business case for sustainable investment in NCD prevention and control (see Part II of this report and annexes for examples of applicable tools) in support of the cost of national action versus inaction, pointing out connections between findings at national and global level, and use these business cases as an integral part of resource allocation and investment decisions from domestic public resources and international development cooperation, where available;

• reiterate the need for targeted actions and quality investments for addressing NCDs in the formulation and implementation of multisectoral policies and plans, including financial, economic, environmental and social policies, and promotion of universal health coverage;

• strengthen safeguards in investment treaties to protect public health and to strengthen policy coherence between the development, health, finance and trade sectors with a view to encouraging them to improve their contributions to health system strengthening and universal health coverage in a way that would also ensure better health outcomes for NCDs, and increase the recognition of health as both an economic and a social investment (with tangible returns);

• strengthen and reorient health systems to address the prevention and control of NCDs through integrated people-centred primary health care and universal health coverage.

Findings

• While it is essential to ensure that NCD prevention, treatment and care interventions are cost-effective and affordable, greater spending on NCDs is feasible and justifiable. Economic growth in many low- and middle-income countries is projected to remain healthy, opening up substantial opportunities for countries to enhance investments in health and other sectors with long-term high returns. Evidence shows that if current investment levels in national NCD responses are maintained, they will be insufficient to attain the NCD-related targets in the Sustainable Development Goals and the nine voluntary targets from the Global Action Plan on NCDs, end poverty and hunger, and achieve sustainable development in its three dimensions through promoting inclusive economic growth, protecting the environment, and promoting social inclusion. Enhanced domestic investment in NCDs in countries is critical to achieving inclusive, equitable and sustainable development for present and future generations.

• An investment framework is needed. National spending targets can then be prioritized, cognizant of projected economic returns to investment, as appropriate.

• Funding from all sources needs to be stepped up to meet the needed NCD investments, recognizing that the combined total of NCD funding from domestic, donor and market-based sources will vary according to country income level and epidemiological conditions.


Opportunities for countries to access innovative financing depend on country context and demonstrated needs. Initiatives to raise financing for NCDs must reflect a solid understanding of how that financing affects the health system and macroeconomic conditions of each country. The Addis Ababa Action Agenda recognizes that price and tax measures on tobacco can be an effective and important means to reduce tobacco consumption and health care costs, and represent a revenue stream for financing for development in most countries. Another example is taxation of unhealthy products. These kinds of trade-offs should be explored transparently when countries consider financing options. Nevertheless, governments already collect nearly US$ 270 billion in tobacco excise revenues each year and, as such, tobacco taxation offers a win–win policy option for governments. Few efforts are being made to increase the allocation of these revenues towards health in most countries, missing a key opportunity to leverage funds for health care purposes.

Insufficient investments in NCDs will also undermine efforts in the post-2015 development agenda to ensure gender equality and empowerment of women and girls.

Globalization of marketing and trade is one of the main factors behind the increase in NCDs to epidemic proportions, though the overwhelming economic costs of inaction in this area often go unrecognized.

Today, 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 41% and 36% of total health expenditure in low- and middle-income countries respectively in 2013, compared to just 15% in high-income countries. Reliance on out-of-pocket expenditure for NCD treatments will further exacerbate health inequalities. A recent WHO and World Bank report shows that 400 million people do not have access to essential health services and 6% of people in developing countries are tipped into or pushed further into extreme poverty (US$ 1.25 per day) because they have had to pay for health services out of their own pockets. However, this report accounts only for those services that are already included in country health benefit packages, thereby offering a vast underestimate of essential health services.

The 2015 Global Reference List of 100 core health indicators recommended by global health agency leaders includes the global target indicators for NCDs. Countries need to move away from out-of-pocket payments through strengthened public health funding in order to reduce the barriers to inclusive and equitable availability of and access to essential people-centred health care services.

In low- and middle-income countries, measures to expand financial protection and improve access to early diagnosis and treatment offer the most visible means of addressing the household economic burden of NCDs. These measures include social health insurance, tax-financed health care and other funding mechanisms that seek to minimize out-of-pocket

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48 Resolution A/RES/69/313, paragraph 32.


payments and interventions to reduce service access barriers. Conditional and unconditional cash transfers will in turn also increase demand for health care.

- When mobilizing and allocating resources to attain the NCD-related targets, countries should consider the nature of their disease burden, and select interventions for prevention and control of NCDs, considering effectiveness, cost-effectiveness, affordability, implementation capacity, feasibility, national circumstances and impact on health equity of interventions. The total cost for implementing a set of very cost-effective and affordable NCD interventions (the “best buys” included in the WHO Global Action Plan on NCDs 2013–2020, Appendix 3) in all developing countries would be US$ 11 billion per year.\(^\text{51}\) WHO estimates that scaling up just six cardiovascular treatment interventions in 20 countries representing 70% of the global cardiovascular disease burden would require US$ 85.4 billion between 2015 and 2030, or US$ 5.7 billion per year. The per capita cost averages US$ 1.52 in those countries.\(^\text{52}\)

4.2 Recommendation 2

Effectively and efficiently utilize and expand domestic public resources to implement national NCD responses, including by making greater use of revenue from tobacco and other health-related taxes to achieve national health objectives.

**Action steps**

Heads of State and Government may select and undertake actions set out below:

- acknowledge that public finance for health is essential and must lead the way to underpin national NCD response implementation;

- accelerate commitments made in 2011 and 2014 to increase and prioritize budgetary allocations for NCDs;\(^\text{53}\)

- mobilize additional funds from a variety of revenue mechanisms, including taxes on unhealthy foods and beverages, income taxes, broader consumption-based value-added taxes or excise taxes on tobacco and alcohol, and social insurance contributions or payroll taxes, depending on the fiscal situation in countries (see Part II and annexes for differentiation of needs);

- explicitly incorporate the prevention and control of NCDs into poverty reduction strategies and also into national sustainable development plans aimed at the poorest income quintiles and those living in extreme poverty;

- ensure that prevention remains the cornerstone of any national NCD response, in particular by fulfilling commitments made in 2011, 2014 and 2015 to accelerate and strengthen the

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\(^{52}\) Scaling up non-communicable disease prevention: a return on investment analysis. WHO Department of Health Systems Governance and Financing; 2015.

\(^{53}\) See paragraph 45(c) of resolution A/RES/66/2 and paragraph 30 of resolution A/RES/68/300.
implementation of the WHO FCTC, and prioritizing the implementation of four specific demand reduction measures of the WHO FCTC to reduce the affordability of tobacco products, three specific measures to reduce the harmful use of alcohol, and four specific measures to reduce unhealthy diets, in preparation for the third United Nations High-level Meeting on NCDs in 2018;

- increase tobacco excise tax revenues and allocate a portion of the proceeds to increase health expenditure on the prevention and control of major NCDs, and generate additional domestic resources through innovative financing tools to implement national NCD responses;

- ensure that ministries of health effectively engage with their counterparts in ministries of finance and planning to make a credible case for more domestic public resource investment for NCDs, based on nationally generated evidence;

- ensure that ministries of health build economic capacity and use available toolkits to prepare NCD business cases, including co-financing approaches, and better track and measure the cross-sectoral impacts of action on the social determinants of NCDs.

**Findings**

- NCD prevention, treatment and care should be part of universal health coverage packages supported by public funding. Countries will determine how they progress along the three dimensions of universal health coverage: population coverage for health, prepaid health services, and proportion of needed interventions covered, and where NCDs fit into those needs. Because countries are in various stages of economic and epidemiological transition, a tiered approach to expanding NCD coverage should take into account country income levels.

- Evidence shows that health spending creates large economic benefits; however, most low- and middle-income countries underinvest in health. The top five development investment opportunities in the 2012 Copenhagen Consensus were in the areas of health and nutrition. Figure 2 shows public health expenditure over time for low- and middle-income countries, by country income level. The proportion of health spending that comes from public coffers is far

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54 See paragraph 43(c) of resolution A/RES/66/2 and paragraph 20 in resolution A/RES/68/300, as well as paragraph 77 in the Addis Ababa Accord.

55 These are (a) reduce affordability of tobacco products by increasing tobacco excise taxes; (b) create by law completely smoke-free environments in all indoor workplaces, public places and public transport; (c) warn people of the dangers of tobacco and tobacco smoke through effective health warnings and mass media campaigns; and (d) ban all forms of tobacco advertising, promotion and sponsorship. See [http://www.who.int/nmh/events/2015/getting-to-2018/en/](http://www.who.int/nmh/events/2015/getting-to-2018/en/).

56 These are (a) regulations over commercial and public availability of alcohol; (b) comprehensive restrictions or bans on alcohol advertising and promotions; and (c) pricing policies such as excise tax increase on alcohol beverages. See [http://www.who.int/nmh/events/2015/getting-to-2018/en/](http://www.who.int/nmh/events/2015/getting-to-2018/en/).

57 These are (a) adopt national policies to reduce population salt/sodium consumption; (b) adopt national policies that limit saturated fatty acids and virtually eliminate industrially produced trans fatty acids in the food supply; (c) implement the WHO set of recommendations on marketing of foods and non-alcoholic beverages to children; and (d) fully implement legislations and regulations related to the International Code of Marketing of Breast-Milk Substitutes. See [http://www.who.int/nmh/events/2015/getting-to-2018/en/](http://www.who.int/nmh/events/2015/getting-to-2018/en/).


lower in low- and middle-income countries than in high-income countries, and has increased only gradually over time. Progress is possible with sustained political commitment. In Indonesia, for example, national health expenditure grew to 5% of the national budget over seven years. Of local budgets in Indonesia, 10% are intended to be spent on health – 40% of communities have complied to date.\(^{60}\)

**Figure 2. Public spending on health in low- and middle-income countries as a percentage of GDP, 1995–2013**

Countries can increase public spending on health in three ways: (a) raise more tax revenues to spend on all public services, including health (“fiscal capacity”); (b) allocate a greater share of available funds to health; and (c) capture part of the “dividend” from economic growth to increase overall public spending on health. They can also strive to reduce waste and improve efficiency by better linking health financing to service delivery (“more health for the money”).

- Out-of-pocket payments are high for NCDs and impoverish people and their families, and voluntary prepayment mechanisms are insufficient to protect people from financial ruin – most people instead go without care.\(^{61}\)

- An important aspect of domestic financing is that ministries of health must have the ability to demonstrate that they can use money well and to make a credible case for more. It is crucial to getting more health for the money by managing the health system efficiently, demonstrating the value of investing in health, and then bringing the nationally generated evidence to make the case for scaling up investment to meet NCD needs. Part of this means ensuring that ministries of health effectively engage with their counterparts in ministries of finance.

- The Addis Ababa Action Agenda provides important messages on measures such as more efficient tax collection, a reduction in tax avoidance and illicit financial flows, and the generation of new revenues through innovative means, each of which is essential for

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expanding fiscal space, and could be vital if focused on the health goal and NCD-related targets in the Sustainable Development Goals.

- Tobacco taxes are an especially credible source of increased domestic funding for NCD programmes. Countries are increasingly linking revenues from increasing tobacco taxes to funding universal health coverage. More than US$ 270 billion is already raised each year by governments in tobacco taxes, generating extra public revenues, reducing consumption, improving health, slowing the growth of health care costs, protecting poorer segments of the population, and combating poverty. Key demand reduction strategies of the WHO FCTC can drive sustainable development, as described in the WHO report on the global tobacco epidemic, 2015.

- Raising funds through health-related taxes is important for revenue increase, but their public health objectives and population health impacts, for example reductions in the consumption of products harmful to health, should remain at the centre.

4.3 Recommendation 3

Complement domestic resources for NCDs with official development assistance (ODA) and catalyse additional resources from other sources to increase health expenditure on the prevention and control of NCDs, consistent with country priorities.

Building on their call in 2014 for the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee to track ODA for NCDs, and recognizing that an important use of that ODA would be to catalyse additional resources from other sources to increase health expenditure on the prevention and control of NCDs, international development agencies must grasp the opportunity presented by the 2030 Agenda for Sustainable Development to mobilize domestic support towards the fulfilment of ODA commitments for NCDs, including through raising public awareness, providing data and demonstrating tangible results.

Action steps

Heads of State and Government may select and undertake actions set out below:

- scale up the catalytic role of ODA to complement national efforts to raise public and private finance for national NCD responses;

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63 http://www.who.int/tobacco/en/.

64 A call to develop a creditor reporting system code for NCDs. The standard source for data on ODA is the OECD creditor reporting system database maintained by the OECD Development Assistance Committee, in which there is so far no marker for NCDs. See paragraph 33 of the outcome document of the high-level meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of non-communicable diseases, 2014: http://www.who.int/nmh/events/2014/a-res-68-300.pdf?ua=1.

continue to push for high-income countries to achieve the target of devoting 0.7% of their gross national income to development assistance;

address the needs of the most vulnerable by strengthening the equity approach to ODA and ensuring that the strategic focus of lending, grants and technical assistance provided by multilateral development banks and other international development banks includes improving health conditions for the poor and specific NCD loans;

treat requests for donor assistance for NCDs in the same manner as donor assistance requests in other areas of public health, with comparable documentation and analysis;

create very clear health performance metrics to offer donors and other financers of NCD programmes, combined with economic performance measures using the tools described in Part II and annexes of this report;

harness the role of ODA to develop institutional capacity with adequate knowledge and skills for developing national NCD responses in the poorest and most vulnerable countries with limited domestic resources;

ensure that WHO is adequately resourced to support national NCD responses to achieve the NCD-related targets in the Sustainable Development Goals;

employ the know-how of international development agencies to explore pathways for collaboration, including North–South, South–South and triangular cooperation on technical support. Domestic avenues of collaboration should involve the full range of ministries, including the ministry of finance, in order to access the benefits that can be derived from multisectoral cooperation. All partners should continue to work for more efficient delivery of international development cooperation, exploring, developing and documenting ways to reduce fragmentation and align behind comprehensive national health plans, in accordance with International Health Partnership (IHP+) principles of development effectiveness.

Findings

Donor assistance for NCDs is out of proportion to the burden of disease, as a very small share of those donor assistance funds are currently allocated to NCDs. As seen in Figure 3, NCDs only accounted for an estimated 1.7% of all donor assistance for health in 2014, or US$ 611 million out of US$36 billion. Figure 4 shows the allocation of donor assistance for health from three main sources: bilateral donors, multilateral donors and nongovernmental organizations (NGOs).

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The prioritization of the global burden of NCDs needs to be strengthened among bilateral, multilateral and international private donors. Bilateral donors are the dominant funding source in global health, providing 52% of overall donor assistance for health, but only 11% for NCDs in 2011 (US$ 40 million). The World Bank and WHO each provided 9% of the 2011 donor funding for NCDs. Since 2000, the WHO programme budget allocation to the NCD area has increased steadily but is still small, given the global burden of disease and opportunities for prevention and effective control. NGOs based in the United States of America, as a group, provide US$ 100 million for NCDs annually – almost as much as multilateral organizations provide, and far more than bilateral donors. 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. The magnitude of NCD funding from these sources is not known, but is estimated to be at least as much as NCD donor assistance for health.


• ODA, in particular, serves a critical role to develop institutional capacity with adequate knowledge and skills to formulate national NCD responses in the poorest and most vulnerable countries with limited domestic resources. These countries face special challenges. For instance, the WHO country capacity surveys on the prevention and control of NCDs conducted in 2000, 2005, 2010 and 2013 confirm that low-income countries lack the capacity to generate or leverage domestic resources, such as taxes on tobacco and alcoholic beverages. Global donor support for technical and institutional capacity to enable countries to implement policies can provide essential capacity to address NCD risks.

• International development cooperation will need to financially support domestic efforts in the poorest countries to achieve the NCD-related targets included in the Sustainable Development Goals by 2030 and the nine voluntary targets of the Global Action Plan on NCDs by 2025. It is unrealistic to expect that low-income countries will be able to reduce premature mortality from NCDs by one third by 2030 without help in the short term. Although many countries may experience healthy economic growth, low-income countries will experience sustained need for external resources, largely in the form of development assistance.

• The donors need to have plans for NCDs that are well aligned with country priorities.

4.4 Recommendation 4

Promote and incentivize financing and engagement from the private sector to address NCDs consistent with country priorities on NCDs.

Building on governments’ commitments made in 2015 (to engage private sector entities as partners in implementing ambitious national Sustainable Development Goal responses, and to strengthen regulatory frameworks to better align private sector incentives with public goals), governments must incentivize the private sector to invest in areas critical to addressing NCDs, while regulating the marketing of food and non-alcoholic beverages to children, promoting and encouraging production of food products consistent with a healthy diet, reducing the use of salt in the food industry, and improving access to and affordability of medicines for NCDs.

Action steps

Heads of State and Government may select and undertake actions set out below:

• protect national policies for the prevention and control of NCDs from undue influence by any form of vested interest in order to harness contributions from the full range of private sector entities; real, perceived or potential conflicts of interest must be acknowledged and managed, recognizing the fundamental conflict of interest between the tobacco and arms industries and public health;

• create safeguards to ensure that revenue from private sources is well aligned with national NCD goals, that funds flow in a stable and predictable way to allow for their efficient use, and that public health priorities, policies and standards are respected;

• encourage philanthropic donations to support national NCD responses and encourage philanthropic donors to consider managing their endowments through impact investments in NCDs;

• share responsibility for the achievement of national NCD targets (and the NCD-related targets in the Sustainable Development Goals and the nine global voluntary NCD targets) with the private sector, and create opportunities to use the knowledge and experience of the private sector through government-led public–private and multistakeholder partnerships;

• establish a multistakeholder platform to share knowledge and data to support collective action for engagement on, and implementation, monitoring and evaluation of, measures to prevent and control NCDs, while involving all relevant stakeholders, including private sector entities, to establish and maintain accountability;

• promote bolder measures to mandate approaches, ranging from statutory regulation to co-regulatory mechanisms, that encourage (a) the food and non-alcoholic beverage industry to take measures to implement the WHO set of recommendations to reduce the impact of the marketing of unhealthy food and non-alcoholic beverages to children, produce and promote more food consistent with a healthy diet, and reduce the use of salt in the food industry; (b) the pharmaceutical industry to improve access to and affordability of NCD medicines and technologies; and (c) all employers to create an enabling environment for healthy behaviours among workers in workplaces;\(^7^0\)

• use tax incentives and other regulatory tools to create an enabling environment for investments from domestic and international private business to align with public NCD goals, including healthy behaviours (prevention and health promotion) among workers, and through appropriate design of health insurance, at their workplaces;

• Develop a robust accountability mechanism to review and ensure effective delivery of the commitments and contributions from the diverse range of private sector entities to national NCD responses and achievement of NCD targets.

Findings

• Governments have the primary role and responsibility of responding to the challenge of NCDs and should lead national responses to NCDs. However, relevant State and non-State actors need to be engaged for NCDs to be tackled effectively.

• Governments require the contribution and cooperation of private sector entities, which are key players as providers of goods and services that can have important effects on health and health inequities. Governments should articulate clear roles and contributions towards NCD prevention and control from the large and diverse range of private sector entities. Relevant private sector entities include the food and beverage, hospitality, tourism, media, sports and fitness, insurance, health service, banking, advertising, entertainment, pharmaceutical, service and transport industries, and industries responsible for the environment. In addition, all private sector entities employ workers, and as such are responsible for protecting the health

\(^7^0\) United Nations Political declaration on NCDs, 2011, paragraph 44.
and safety of their workforce and can contribute directly to promoting and supporting good health.\textsuperscript{71}

- Governments need to safeguard public health interests from undue influence by any form of real, perceived or potential conflict of interest to effectively prevent and control NCDs. Many private sector entities may have no direct conflict in being involved in NCD prevention and control and in fact may have objectives that align closely with those of governments.

- There is an urgent need to scale up the multiple contributions of the diverse range of private sector entities to national-level NCD prevention and control. It is important that governments are clear about the varied roles and contributions of the diverse range of private sector entities in NCD prevention and control.

- There is a need to be much more discerning when considering the varied roles of the range of private sector entities in order to differentiate the contributions that different entities can make, and therefore the nature of engagement with those different entities. Government-led public–private and multistakeholder partnerships can focus on the achievement of national NCD targets (and the NCD-related targets in the Sustainable Development Goals).

- Just as making an effective economic case to ministries of finance can yield investment, so making an effective business case to private sector entities can yield greater investments in the health and productivity of their workforce, including as it relates to NCDs.

- In September 2011, Heads of State and Government committed to call upon the private sector to take measures to (a) reduce the impact of marketing of unhealthy foods and non-alcoholic beverages to children; (b) produce and promote more food products consistent with a healthy diet; (c) promote and create an enabling environment of healthy behaviours among workers at the workplace; (d) reduce the use of salt in the food industry; and (e) improve access to and affordability of NCD medicines and technologies.\textsuperscript{72} Progress in fulfilling this commitment has been slow.

- Similar to national responses to the overall implementation of the Sustainable Development Goals, the national responses to the NCD-related targets will need to be financed through the mobilization and effective use of domestic resources and strengthened international cooperation (both public and private) over the next 15 years, as set out in the Addis Ababa Action Agenda.

- The WHO GCM/NCD Working Group on how to realize governments’ commitments to engage with the private sector for the prevention and control of NCDs has made a set of findings and recommendations.\textsuperscript{73}

- The World Trade Organization (WTO) Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and its flexibilities allow WTO members to protect public health and

\textsuperscript{71} WHO Global Coordination Mechanism draft final report and recommendations from the Working Group on how to realize governments’ commitments to engage with the private sector for the prevention and control of NCDs, November 2015.

\textsuperscript{72} See paragraph 44 of resolution A/RES/66/2.

\textsuperscript{73} http://who.int/global-coordination-mechanism/working-groups/wg-3-1-private-sector/en/.
improve access to affordable essential medicines for developing countries, but it is not clear that these approaches are being pursued in any systematic way.\textsuperscript{24}

### 4.5 Recommendation 5

Enhance policy coherence across sectors in order to ensure that the expected outcomes of national NCD policy are achieved, including by assessing the health impact of policies beyond the health sector.

**Action steps**

Heads of State and Government may select and undertake actions set out below:

- accelerate the commitments made in 2011 and 2014 to integrate national responses to NCDs explicitly into existing national public health programmes on HIV, reproductive health, maternal, child and adolescent health, and universal health coverage;\textsuperscript{75}

- accelerate the commitments made in 2011 and 2014 to develop multisectoral NCD policies and plans before 2016. This should include, as appropriate, strengthening and orienting health systems towards the prevention and control of NCDs and the underlying social determinants through people-centred primary health care and universal health coverage throughout the life cycle, building on guidance set out in Appendix 3 to the Global Action Plan on NCDs;\textsuperscript{76}

- incorporate NCD goals into comprehensive planning processes and documents, including national health and development, infrastructure and human resource plans, coordinated with the United Nations Development Assistance Framework (UNDAF), \textsuperscript{77} WHO country cooperation strategies, and other broad health system procedures and guidance;

- consider establishing national multisectoral high-level commissions for policy coherence and mutual accountability of different spheres of policy-making that have a bearing on NCDs,\textsuperscript{78} and support the establishment of United Nations country team thematic groups on NCDs;

- find ways for ministries of health to leverage contributions from other sectors towards mutual NCD objectives by developing multisectoral policies and plans and setting national targets on NCDs;

- promote better alignment between existing global health initiatives, such as the Global Fund\textsuperscript{79} and the GAVI Alliance, with a view to encourage them to improve their contribution to health system strengthening and universal health coverage in way that would also ensure better health outcomes for NCDs;

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\textsuperscript{24} A new initiative is the United Nations Secretary-General’s High-level Panel on Access to Medicines: http://www.unsgaccessmeds.org/.

\textsuperscript{75} See paragraph 45 in resolution A/RES/66/2 and paragraph 30 in resolution A/RES/68/300.

\textsuperscript{76} See resolution A/RES/68/300, paragraph 30(c).

\textsuperscript{77} http://who.int/nmh/ncd-task-force/guidance-note.pdf?ua=1.

\textsuperscript{78} See paragraph 30(a)(vi) of resolution A/RES/68/300. Also, note example of Finland’s Multisectoral Commission.

\textsuperscript{79} GF/B33/11, Board Decision: Global Fund support for co-infections and co-morbidities.
• assist low- and middle-income countries to increase their capacity to assess NCD burden and needs in the realms of financing, human resources, research, facilities, drugs and other supplies and equipment, all in view of stated NCD and health priorities and constraints (see Part II and annexes for assessment tools).

Findings

• Regulatory gaps and misaligned incentives continue to pose risks to undermine national NCD efforts. In 2014, ministers committed to consider establishing national high-level commissions for policy coherence and mutual accountability of different spheres of policy-making that have a bearing on NCDs. Some have been created and now play a critical role in identifying ways for non-health sectors, such as agriculture, transport and planning, to support prevention of NCDs while achieving their own goals. Calculation and measurement of these co-benefits is important.

• The offer of technical assistance services by developed and developing countries, United Nations agencies, philanthropic foundations, NGOs and the private sector is largely segmented. There is a huge, and largely untapped, potential for public, philanthropic and private actors to work together to support national NCD responses and thereby improve coherence.

• Improved policy coherence and alignment would both support universally agreed aid effectiveness principles and facilitate achievement of NCD targets.

5. Creating an enabling environment

5.1 Addressing different information needs and knowledge gaps

There is a clear need for a strong knowledge base and enhanced domestic data for effective and sustained NCD action. Not enough is known about country demands, financing needs, efficient allocation of resources for NCDs, or existing and potential sources of finance and cooperation mechanisms. Governments should work to improve knowledge about NCD actions, including research, monitoring and evaluation capacity to ensure accountable and appropriate resource allocations. High-quality disaggregated data on NCD mortality and morbidity, risk factors and national system responses are an essential input for smart and transparent decision-making and can improve policy-making at all levels. This is especially critical to be able to achieve universal health coverage and include NCDs in poverty reduction strategies.

5.1.1 Need for enhancing domestic data

In 2011, Heads of State and Governments committed to prioritizing budgetary allocations for NCD surveillance; yet, implementation and surveillance measures for NCDs are still inadequate. Countries must enhance national data to make a clear case for investment in the prevention and control of NCDs. Governments need to assess their NCD burden, risk factor profiles, expenditure, 

80 See paragraph 30(a)(vi) of resolution A/RES/68/300.


82 https://twitter.com/ncdscore.
cost of services, availability of resources (human and infrastructural) and potential for international and national cooperation with non-State actors.

Funding from private, official and non-traditional donors is particularly opaque at both global and country levels, and may constitute a substantial share of external funds nationally for NCDs in the near term. Indicators for tracking and monitoring progress in NCD financing that incorporate differential risks and outcomes within populations need to be agreed upon.

National health information systems have a central role in generating, analysing and disseminating data on NCDs, but require strengthening in many countries. These official government data sources can be supplemented with data and analysis from civil society, academia and the private sector. Disaggregating the economic and health burdens of NCDs is also required to better understand the effects on poverty and on women and other vulnerable segments of the population. Specific indicators and data needs are outlined in Annex 4 (Democratic Republic of the Congo country example of NCD expenditure).

5.1.2 Need for identifying and sharing information on country demands, sources of finance and cooperation mechanisms

The Working Group welcomes objective 5 of the WHO GCM/NCD work plan for 2016–2017, which aims at identifying and sharing information on country demands and existing and potential sources of finance and cooperation mechanisms at local, national, regional and global levels for implementation of the WHO Global Action Plan on NCDs 2013–2020. Relevant and selected participants will be mobilized to conduct 12 studies (two per WHO region) on the national public health burden caused by NCDs in developing countries; the relationship between NCDs, poverty and social and economic development; and the cost of inaction versus the cost of action. The outcome of the studies will be published in 2016 and 2017.

5.2 Steps toward realizing commitments to finance prevention and control of NCDs

5.2.1 Public health sector expenditure in developing countries

Overall, public sector expenditure on health is relatively small in developing countries compared to more developed countries. For example, while government expenditure in advanced economies is on average 45% of GDP, the average is less than 24% in low-income countries. Further, government budgets for health have increased slowly in low- and middle-income countries (see Figure 2). Among the promising means to increase the public sector’s ability to provide services are:

- increased tobacco taxation;
- improving tax compliance and the efficiency of revenue collection in countries, and increasing tax rates where these are relatively low;
- introducing new taxes (such as financial transaction taxes);


86 Resolution A/RES/69/313, paragraph 32.
• maximizing revenue from the exploitation of mineral and other natural resources, whether this is through State ownership and operation of these enterprises or increased levels of taxation on private extractive companies.87

5.2.2 International fiscal competition

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;
• 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”;
• reduce transfer pricing by multinational corporations;
• improve transparency around payments to developing country governments by extractive companies88 and tobacco, alcohol, big food and beverage, and pharmaceutical companies.

These actions will provide a better enabling environment for countries to implement fiscal policy actions, in support of both health spending and other priorities.

5.2.3 Need for tools to support countries

Technical assistance to evaluate capacity and prepare NCD needs assessments

Beyond financial resources, countries face large gaps in capacity and availability of human resources, equipment, supplies, infrastructure and management resources that are essential to implementing national NCD and development plans. Countries may also need guidance and technical assistance in order to evaluate capacity and prepare NCD needs assessments, and particularly to avoid further verticality in health service delivery. There are several frameworks in place globally and regionally to provide guidance from WHO and other United Nations agencies.89 The potential for health care integration and “smart procurement” to reduce costs and improve health outcomes should be pursued. Multiple actors, both State and non-State, including civil society, academia, industry, NGOs and professional organizations, need to be engaged for NCDs to be tackled effectively. There are many good country examples of multisectoral and multistakeholder planning that include NCDs (for example from Bangladesh and Mexico). Some of these examples provide successful models of using financing mechanisms to prevent and control NCDs – with both domestic and externally sourced revenues – that can be reviewed and adapted to other country settings. NCD strategies and the necessary resources to fulfil them should be part of country development planning well beyond the health sector.

87 McIntyre D. Policy brief on domestic financing strategies for the GCM on NCDs Working Group 5.1. February 2015.
88 Ibid.
Comprehensive investment framework for NCDs

Investment frameworks exist for HIV/AIDS and women’s and children’s health and have been powerful instruments for facilitating focused and strategic use of scarce resources. A comprehensive investment framework for NCDs is needed. Countries can use tools developed by WHO to assess their own expenditure data, adding or substituting interventions according to national needs or priorities, to inform an investment case for NCDs. Guidance on using available tools is contained in Part II and the annexes to this report.

Global investor platform or “marketplace”

Public and private co-investment in national NCD responses holds enormous potential to contribute to efforts to reduce premature mortality from NCDs. Governments may consider creating a global investor platform (a “marketplace”) for national NCD solutions building on the lessons learned from similar solutions in other areas (for example the European Union Platform for Blending in External Cooperation). One function could be systematically recording demand from developing countries for technical assistance for NCDs.

Community of practice, knowledge sharing and building broad-based and grass-roots NCD-specific advocacy and activism

In line with the World Health Assembly-approved work plan 2016–2017 for the WHO GCM/NCD, which in objective 4, action 4.1, mandates the GCM/NCD to continue supporting communities of practice in 2016 and 2017, Working Group members could be invited to join a community of practice to be created in order to sustain discussion and engagement and to promote and enhance knowledge transfer on these recommendations, particularly at local and national levels. In addition a GCM/NCD web portal will be established for knowledge sharing, with repositories of country cases and research resources, among other elements.

Other actions from international funders, agencies, and advocates are needed to overcome barriers to financing NCDs. These include stronger and more cohesive advocacy, along with greater country-based evidence of the effectiveness and cost-effectiveness of priority policies and interventions. Despite the remarkable work of organizations such as the NCD Alliance in stimulating NCD funding, advocacy and activism will need to become more broad based and involve more grass-roots stakeholders, both in donor countries and in recipient countries. There is a need for strong civil society engagement and a social movement to increase political will to allocate sufficient resources and action to NCDs. In addition to lack of funding, a significant barrier until 2015 was that many countries were guided by the Millennium Development Goals, which lacked an indicator for NCDs. That omission has been remedied with the health goal and the NCD-related goals in the Sustainable Development Goals.

90 See http://www.who.int/choice/onehealthtool/en/.
91 Nugent R. Policy brief on bilateral and domestic financing for NCDs for the GCM on NCDs Working Group 5.1. February 2015.
In addition to developing the above recommendations, and noting information gaps, the Working Group has discussed more tangible steps to help facilitate realization of the commitments made by Heads of State and Government to finance prevention and control of NCDs in the context of the Global Action Plan on NCDs with its nine voluntary targets and to achieve the targets in the Sustainable Development Goals. Part II of this report lays out a preliminary approach to help countries identify NCD financing options for NCDs. This part of the report emerges from an iterative process among the members of the Working Group, assisted by the WHO Secretariat. It provides an early vision of a process to prepare countries to successfully finance NCD needs, including demonstrating the value of different tools and steps available for Member States to facilitate financing options. These include an NCD investment case for Barbados, prepared using the United Nations OneHealth Tool, and annexes with other practical tools.
Part II

6. Approaches and tools for assessment and implementation of national NCD financing options

In this part of its report, the Working Group of the WHO GCM/NCD, mandated to recommend ways and means of encouraging Member States and non-State actors to realize the commitment to “explore the provision of adequate, predictable and sustained resources, through domestic, bilateral, regional and multilateral channels, including traditional and voluntary innovative financing mechanisms”, offers an approach aimed at assisting countries to implement the needed actions to cost, prioritize and build an investment case for NCD response. The process and tools provided here are preliminary and largely untested. They are based on Working Group deliberations, expert input, and early experience with WHO tools in a limited number of countries, and are informed by similar frameworks developed for other disease priorities in the health sector, such as the HIV financial sustainability framework.

The process will have to be refined after further testing, with the intention of ultimately producing a framework for NCD financing.

6.1 Rationale for stepwise approach to support implementation of national NCD financing

Few countries to date have been able to reconfigure their health systems or raise the resources necessary to adequately meet the new reality of a rapidly ageing population and increased levels of chronic disease. High-, middle- and low-income countries alike now therefore need to give serious consideration to the question of how their economies will be able to cope with the rapidly escalating burden of NCDs, not only in terms of health and social services but also in terms of mitigating the economic fallout from diminished labour force participation and productivity.

To achieve the global target of 25% reduction in premature preventable deaths from NCDs by 2025, many countries will need to reorient and reconfigure their health systems. Success requires the ability to provide people-centred care, through a whole-of-society approach, with improved outreach and self-management to effectively manage risk factors, illness episodes and multimorbidity. Global technical agencies and donors need to support country planning and priority setting based on evidenced-based information regarding the local disease burden disaggregated for equity, intervention effectiveness and costs, focused on the “best buys”, as outlined in Appendix 3 of the WHO Global NCD Action Plan 2013–2020, as well as operational considerations related to integration of care delivery models.

The annexes to this report provide examples of the tools that can be used in the process of assessing and implementing an NCD financing process at the country level. There are five steps to the process, as shown in Figure 5 and further described below.

- assess domestic NCD disease burden
- assess national health system capacity
- assess resource needs

• assess domestic macroeconomic and fiscal capacity
• assess NCD financing options.

These steps allow countries to characterize the national health and economic situation, and identify NCD financing options on the basis of current and projected health system and resource constraints and the potential of the economy to generate additional resources for NCDs and the health sector more generally.

**Figure 5. A five-step process for assessing NCD financing options**

6.2 **Five steps for assessing and implementing NCD financing process at country level**

6.2.1 **Step 1: NCD disease and risk factor burden assessment**

An appropriate first step is to ascertain the current and projected domestic disease burden associated with NCDs and their primary risk factors (tobacco and harmful alcohol use, unhealthy diet and physical inactivity). Key data required to inform attributable NCD disease burden estimates include:

- current (and, where possible, trends in) prevalence of risk factor exposure, disease incidence, and NCD cause-specific mortality (where possible disaggregated by age and sex);
- current and projected estimates of the population size and growth (disaggregated by age and sex);
- relative risks for the incidence and mortality of NCDs, by risk factor (which characterize the relationship between exposure to a risk factor and consequent disease outcome).

Such data should be generated at national level through the conduct of a national burden of risk factor and disease assessment, such as the WHO Global Monitoring Framework for NCDs, the STEPwise approach to chronic disease risk factor surveillance (STEPS), the global school-based student health survey (GSHS), country capacity surveys on NCDs (NCD CCS), the global youth tobacco survey (GYTS), and MPower.93 Demographic, epidemiological and relative risk information is also available

through international sources, including the United Nations Population Division and the WHO mortality, NCD risk factor and global disease burden databases. Country-specific estimates of disease burden by cause are available from WHO global health estimates.94

In addition, estimation of the national economic burden of NCDs can be undertaken, which relates the prevalence of NCDs and related risk factors to their financial and economic consequences, in particular health service costs and lost productivity. Examples of country-level estimations of this kind can be found for China and India.95

6.2.2 Step 2: National health system assessment

The second step is to undertake a health system assessment at national level. A suitable structure for carrying out this assessment exercise is available in the form of the WHO Health Systems Framework, which includes six functions or “building blocks” for health system strengthening: governance, health workforce, financing, service delivery, essential health technologies, and information systems. One example of a comprehensive health system assessment manual has been developed around this WHO framework by the United States Agency for International Development (USAID).96 It provides detailed guidance on the types of questions, activities and outputs that can form such an appraisal. The WHO Regional Office for Europe has prepared a manual for health system assessment specifically designed to assess NCD needs. The guide outlines a five-step process to arrive at policy-relevant and contextualized conclusions.97 The WHO country capacity surveys on NCDs98 and the WHO Service Availability and Readiness Assessment (SARA) survey99 will give very useful information.

Whichever manual or other guidance is used, application of the WHO Health Systems Framework to the national NCD situation can address a range of relevant contextual issues and questions for sustainable financing. Many of the most salient questions that arise in this process are set out in Box 2. Responses to these questions can be informed both by available quantitative indicators – relating to workforce availability and spending levels, for example – and by qualitative feedback from interviews or discussions with senior health policy experts in the country.

As the purpose of such a health system assessment is to inform sustainable financing options, a particularly important part of it concerns current financing arrangements, both in terms of determining overall amounts flowing to NCDs, and in terms of ascertaining the relative contribution of households, governments and NGOs towards the costs of care and prevention. Such information can be gathered through National Health Accounts reporting.100 Annex 4 of this report offers an example of NCD expenditure in the Democratic Republic of the Congo.

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100 Available in-country or via http://www.who.int/health-accounts.
### Box 2. Health system assessment questions, by category

<table>
<thead>
<tr>
<th>Health system function</th>
<th>Examples of health system assessment questions</th>
</tr>
</thead>
</table>
| Governance             | What is the level of policy awareness and commitment to NCDs?  
                          | Is there an explicit national NCD policy and action plan?  
                          | If so, what are its key features and objectives, and over what period is it to be implemented?  
                          | To what extent has an intersectoral, multistakeholder approach to its development been pursued?  
                          | To what extent has the NCD action plan been implemented already at subnational level?  
                          | Is there an authority with lead responsibility for implementing, monitoring and evaluating the NCD action plan? |
| Financing              | What is the current level of total health spending in the country?  
                          | What proportion of health spending is paid by government?  
                          | What proportion of total health spending is directed to NCDs?  
                          | What health insurance or other financial protection arrangements are in place? What if any exemption measures exist for the poor?  
                          | What NCDs are covered by financial protection measures? |
| Health workforce       | What is the current availability of NCD specialist health workers?  
                          | What is the current availability of non-specialist workers? What role do they play in the prevention and control of NCDs?  
                          | What training programmes for non-specialist workers are in place for building capacity in NCD prevention and control?  
                          | What measures are in place to enhance worker performance and retention (for example supervision, performance-related pay)? |
| Essential health technologies | What is the process for selecting essential medicines (for NCDs)?  
                                      | What measures are in place to control the price and rational prescribing of medicines?  
                                      | What is the volume and price of the most commonly used medicines for NCDs?  
                                      | What proportion of the population in need do not have physical or financial access to essential medicines? |
| Information systems\(^\text{101}\) | What surveillance systems are in place to monitor risk factors for NCDs? Is there a recent STEPS or other survey to inform policy?  
                                      | Are patient-level data on service uptake and outcomes for NCDs available through routine health information systems?  
                                      | What mortality data are available?  
                                      | What disease registry data are available?  
                                      | What risk factor data are available?  
                                      | What health system indicators for NCDs are routinely reported? |
| Service delivery       | How are health services organized? What services and interventions for NCD control and prevention are provided at different levels of the health system (and by whom)?  
                          | To what extent is the prevention and control of NCDs integrated into general health care (for example primary health care)? |

\(^{101}\) For more information: [http://who.int/ncds/surveillance/en/](http://who.int/ncds/surveillance/en/)
6.2.3 Step 3: Domestic macroeconomic and fiscal assessment

The third step involves building an understanding of the broader macroeconomic and fiscal situation in the country (see Annex 5 for data requirements and explanation). Critical measures of economic performance and progress include current and projected output (total and per capita GDP), levels of borrowing and debt (as a percentage of GDP) and inflation (year-on-year change in consumer price levels). National employment and capital investment rates represent further important measures, given the role of labour and capital in determining overall levels of economic activity. Measures of poverty and income inequality provide important complementary information on the distribution of national wealth.

Analysing the macroeconomic situation will help countries understand their options and constraints when it comes to generating additional internal funds or attracting external funds for NCDs. A country that is experiencing or expecting a prolonged period of economic growth, with manageable levels of indebtedness and a robust tax collection system, is likely to have a very different set of policy options compared to a country with a stagnant economy or one with a high level of indebtedness, weak tax collection, and reliance on external development assistance. In other words, the former country can be expected to have fewer constraints on public spending and therefore more fiscal space to expand services for NCD control and prevention.

Key fiscal measures include overall levels of government revenue and expenditure, including the running deficit (again as a percentage of GDP). The percentage of total government expenditure allocated to health provides a broad measure of the priority given to this sector in relation to others (and can be benchmarked against agreed targets such as the Abuja Declaration,\textsuperscript{102} which states that governments should be aiming to devoting 15% of their expenditure to health). Box 3 shows the range of macroeconomic and fiscal indicators that are needed to assess financing options, and how they can be used.

<table>
<thead>
<tr>
<th>Box 3. Examples of indicators to assess macroeconomic and fiscal conditions for national NCD financing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicators</strong></td>
</tr>
<tr>
<td><strong>Macroeconomic and development indicators</strong></td>
</tr>
<tr>
<td>Per capita GDP</td>
</tr>
<tr>
<td>Rate of growth of GDP (average for last three years)</td>
</tr>
<tr>
<td>Rate of inflation (same as for GDP growth rate)</td>
</tr>
<tr>
<td>Poverty headcount ratio</td>
</tr>
<tr>
<td><strong>Public finance indicators</strong></td>
</tr>
<tr>
<td>Tax revenue as % of GDP</td>
</tr>
<tr>
<td>Revenue as % of GDP</td>
</tr>
<tr>
<td>Central government debt as % GDP</td>
</tr>
<tr>
<td><strong>Health outcomes</strong></td>
</tr>
<tr>
<td>Millennium Development Goal and Sustainable Development Goal performance</td>
</tr>
<tr>
<td>DALYs lost, top five causes (burden of disease)</td>
</tr>
</tbody>
</table>

\textsuperscript{102} http://www.who.int/healthsystems/publications/abuja_declaration/en/
Malnutrition prevalence  
Age-specific mortality rates from major NCD causes  
Prevalence of major NCDs

<table>
<thead>
<tr>
<th>Health financing indicators</th>
<th>These indicators would be useful to understand the current health financing situation in the country and to what extent governments prioritize health, the extent to which people suffer financial hardship to access health care, and the country’s dependence on external finances for health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current health spending as % of GDP</td>
<td></td>
</tr>
<tr>
<td>Per capita health spending</td>
<td></td>
</tr>
<tr>
<td>Public spending on health (as % of total health spending)</td>
<td></td>
</tr>
<tr>
<td>Out-of-pocket spending (as % of total health spending)</td>
<td></td>
</tr>
<tr>
<td>% of external assistance in total health spending</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Access to health services</th>
<th>These indicators together with out-of-pocket spending generally signify the access issues around health services and indicate how robust the health sector is</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to essential NCD medicines</td>
<td></td>
</tr>
<tr>
<td>% of children fully immunized</td>
<td></td>
</tr>
<tr>
<td>% of institutional deliveries</td>
<td></td>
</tr>
<tr>
<td>Unmet need for contraception</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Spending on NCDs</th>
<th>Self-explanatory; will determine the gap in financing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per capita spending on NCDs (difficult to get but countries will need to do this)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Universal health coverage status</th>
<th>Universal health coverage or lack of it would to a great extent help in understanding whether existing mechanisms can be used to leverage finances for NCDs</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of essential health services coverage that all populations have, independent of household income, expenditure or wealth, place of residence or sex (target: at least 80%)</td>
<td></td>
</tr>
<tr>
<td>% of financial protection from out-of-pocket payments for health services for everyone (target: 100%)</td>
<td></td>
</tr>
</tbody>
</table>

Such measures of economic performance and fiscal activity are regularly collected and compiled by the World Bank and International Monetary Fund, and can be extracted and synthesized into a country profile that shows latest estimates and also (historical and projected) trends over time. Core indicators are given in Figure 6 for three illustrative countries (for the year 2013), which shows for example how economic growth varies from 1% to 10% and debt levels range from 22% to 65% of GDP.

Figure 6. Core macroeconomic and fiscal indicators for three countries

Part (a): Macroeconomic indicators

Part (b): Core fiscal indicators


6.2.4 Step 4: Assessment of resource needs for national NCD prevention and control

Step 4 makes use of the information gathered in steps 1–3 to generate estimates of overall national resource needs and costs associated with the scaled-up delivery of integrated, effective and cost-effective NCD interventions. For countries already providing NCD services, several additional types of information will help plan a scaling-up strategy:

- Coverage estimates, and localized measures of effectiveness, for the prioritized NCD prevention and control strategies. Current coverage may be available from national population-based surveys that include questions about NCD health service use, or from routine health information systems. Target coverage levels are more likely to be arrived at via

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104 Appendix 3, Global Action Plan on NCDs. http://apps.who.int/iris/bitstream/10665/94384/1/9789241506236_eng.pdf?ua=1
expert consensus, taking into account current levels of service coverage and equity as well as future levels of expected need and economic growth.

- Estimates of the resource needs and costs of specific selected NCD strategies, including the price or unit costs of key inputs (for example salaries, drug prices and health care visits).

An NCD costing and health impact module containing country-specific default estimates for all required parameters has been developed recently by WHO. It forms part of a health system strategic planning tool – the OneHealth Tool (see Annex 5 for a list of data requirements for using the OneHealth Tool and Annex 6 for preliminary results from its application to NCDs in Barbados).

6.2.5 Step 5: Identification and selection of financing mechanisms

Step 5 will assist countries in narrowing the choices of financing options. As discussed earlier in this report, the primary modes of health financing can be categorized into domestic financing; bilateral or multilateral funding; and other, more innovative, forms of financing. The pursuit of any of these modes of financing will be influenced by a number of considerations, including:

- the amount of investment needed;
- the level of political will to raise new resources for health;
- the amount of fiscal space for raising new resources for health;
- eligibility for bilateral or multilateral funding;
- availability of bilateral or multilateral funding;
- readiness and willingness to enter into innovative types of market-based financing.

Such considerations are likely to be made in the context of the broader international dialogue on financing for development, in particular the renewed emphasis on domestic financing through strengthened revenue collection efforts. For many countries, therefore, a first question will be to what extent domestic financing represents a feasible and sufficient instrument for financing effective and sustained NCD prevention and control as part of a package of measures to be paid for from enhanced revenue generation. For lower-income countries eligible for ODA, a second question could be: To what extent might external funding complement domestically generated resources in order to catalyse NCD service development or system strengthening, and if so, from which source?

In countries where domestic or external funding mechanisms are expected to fall short of requirements or pose a risk to fiscal stability, consideration is needed as to whether market-based financing options present a suitable and feasible approach to generating and providing additional funds for outcome-based scale-up of NCD prevention and control. These and other options are further described and laid out in Annex 7.

Based on the preceding steps, an informed discussion about the most appropriate and feasible financial mechanisms for meeting a country’s budgetary and other resource needs for scaled-up NCD prevention and control activities can take place. The process of selection should be based on (a) a good understanding of the current and projected threat to national public health and economic growth posed by NCDs; (b) up-to-date knowledge about how well positioned the existing national health

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105 The NCD module covers the costing of treatment and prevention activities for the four major diseases and four major risk factors contributing to the NCD burden. It contains impact modules for the four major disease areas. Risk factor impact modules are forthcoming in 2016. [http://www.who.int/choice/onehealthtool/en/](http://www.who.int/choice/onehealthtool/en/).
system is to address and counter this threat (in terms of service delivery, financing and other critical functions); (c) awareness of the wider domestic macroeconomic context within which health and other sectoral development would need to take place; and (d) a clearly articulated and costed investment plan that indicates what is required to meet nationally agreed NCD goals and targets.

Three scenarios that show the key findings, implications and recommendations that could emerge from applying the five-step process to three different national contexts are shown in Table 1. Although the three examples are hypothetical, they demonstrate the marked variations that exist between countries with respect to underlying wealth and capacity, NCD burden, health system responses to this burden, macroeconomic and fiscal performance and, as a consequence, options for moving towards universal health coverage and sustainable financing for NCDs.

Table 1. Three scenarios that could emerge from the proposed five-step assessment process

<table>
<thead>
<tr>
<th></th>
<th>Resource setting</th>
<th>Disease burden / resource needs</th>
<th>Health system profile</th>
<th>Macrofiscal situation</th>
<th>Policy options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Low-income country</td>
<td>Modest but growing NCD burden</td>
<td>Poor service coverage and access and high out-of-pocket spending NCDs a low priority</td>
<td>Weak and reliant on external development assistance High debt-to-GDP ratio</td>
<td>Raise revenues (enhance tax base) Increase prepayment and revenue pooling International financing loan and development bond</td>
</tr>
<tr>
<td>2</td>
<td>Lower middle-income country</td>
<td>Modest but growing NCD burden, NCD plan has been costed</td>
<td>Low service coverage; moderate financial protection Policy commitment to integrate NCDs into primary care</td>
<td>Favourable (high economic growth) Relatively low spending on health</td>
<td>Raise revenues (excise via excise taxes, allocate more money for health from general revenue taxes) Strengthen financial protection Improve service efficiency (via task sharing)</td>
</tr>
<tr>
<td>3</td>
<td>Upper middle-income country</td>
<td>High and escalating Resource needs not estimated</td>
<td>NCD services not well integrated Relatively high (or full) financial protection</td>
<td>Stagnant economy, but open to investors High and rising debt levels</td>
<td>Raise revenues (via greater tax compliance) Pursue market-based financing (ineligible for ODA)</td>
</tr>
</tbody>
</table>

Finally, when innovative financing is an option, countries should consider the criteria outlined in Box 4, which will provide a broad picture of the implications of specific choices.¹⁰⁶

<table>
<thead>
<tr>
<th><strong>Box 4. Criteria to judge financing options for NCDs</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Efficiency</strong></td>
<td>To what extent do new financing mechanisms minimize potential distortions to the economy, for example effect on economic growth, labour supply, and savings or investment? Do new funds in any way retard macroeconomic growth?</td>
</tr>
<tr>
<td><strong>Political feasibility</strong></td>
<td>To what extent is the financing mechanism acceptable to all the relevant stakeholders who are essential to its implementation?</td>
</tr>
<tr>
<td><strong>Harmonization</strong></td>
<td>Will the mechanism increase, decrease, or have no effect on the complexity of the existing overall development assistance for health?</td>
</tr>
<tr>
<td><strong>Sustainability</strong></td>
<td>To what extent does the financial mechanism have longevity, in that it does not decline over time or have a definite or potential end date?</td>
</tr>
<tr>
<td><strong>Stability</strong></td>
<td>To what extent does the financing mechanism provide a stable source of revenue from one year to the next?</td>
</tr>
<tr>
<td><strong>Progressivity</strong></td>
<td>To what extent does the financing mechanism place the burden on those most able to pay for it (vertical equity)?</td>
</tr>
<tr>
<td><strong>Administrative efficiency</strong></td>
<td>What costs are associated with the financing mechanism (financial or administrative)?</td>
</tr>
<tr>
<td><strong>Side-effects</strong></td>
<td>To what extent does the financing mechanism create positive or negative side-effects?</td>
</tr>
<tr>
<td><strong>Additionality</strong></td>
<td>To what extent will the financing mechanism provide new funding?</td>
</tr>
<tr>
<td><strong>Governance</strong></td>
<td>Are there institutional arrangements in place?</td>
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</tbody>
</table>
Conclusion and next steps

7. Conclusion and next steps to support countries for implementation of their national NCD financing options

The WHO GCM/NCD Working Group on Financing for NCDs concludes its work with the five recommendations set out in this report (see chapter 4).

For the next steps, countries are encouraged to undertake actions under each of the five recommendations, as well as to review and to share experiences that strengthen national capacity to use the available tools set out in Part II and the annexes to this report for assessing needs and capacity for financing NCD prevention and control. There is a need to develop a stepwise process to facilitate financing for NCDs at a country level and to increase capacity and knowledge to use all available tools.

The WHO GCM/NCD together with partners will further explore ways to create an enabling environment and address the information and knowledge gaps (chapter 5), namely:

- identify and share information on country demands and existing and potential sources of finance and cooperation mechanisms;\(^{(107)}\)
- develop technical assistance to evaluate capacity and prepare NCD needs assessments;\(^{(108)}\)
- develop a comprehensive investment framework for NCDs;\(^{(109)}\)
- create a global investor platform (“marketplace”);
- further support advocacy, set up a community of practice and develop knowledge sharing.\(^{(110)}\)

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\(^{(107)}\) Objectives 2 and 5 of the WHO GCM/NCD work plan, see http://www.who.int/global-coordination-mechanism/working-groups/whaa68_gcm_workplan_2016_17a.pdf?ua=1.

\(^{(108)}\) Action 5.1 of objective 5 of the WHO GCM/NCD work plan.

\(^{(109)}\) http://who.int/nmh/events/2015/ncd-multisector.pdf?ua=1; action 5.1 of objective 5 of the WHO GCM/NCD work plan.

\(^{(110)}\) Action 4.1 of objective 4 of the WHO GCM/NCD work plan.
Annexes

Annex 1. Resolutions adopted by the United Nations General Assembly and the WHO World Health Assembly that are relevant to the work of the WHO GCM/NCD Working Group on Financing for NCDs.

Annex 2. Relationship of NCD financial mechanisms used in countries with recommendations from WHO GCM/NCD Working Group 5.1.

Annex 3. NCD financing options: 13 country-level examples

Annex 4. National health subaccounts for NCDs: example of Democratic Republic of the Congo

Annex 5. Data requirements for building the NCD investment case using the OneHealth Tool


Annex 7. NCD financing options
WHO Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases

Final report and recommendations from the Working Group on 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 United Nations General Assembly on the Prevention and Control of Non-communicable Diseases.

Annexes
Annexes

Annex 1. Resolutions adopted by the United Nations General Assembly and the WHO World Health Assembly that are relevant to the work of the WHO GCM/NCD Working Group on Financing for NCDs

United Nations General Assembly

2011 United Nations Political Declaration on NCDs and 2014 United Nations Outcome Document on NCDs

- The 2011 United Nations Political Declaration on NCDs includes a roadmap of commitments from governments (http://www.who.int/nmh/events/un_ncd_summit2011/political_declaration_en.pdf?ua=1), including a commitment to engage with the private sector (paragraph 44).


2015 Addis Ababa Action Agenda


2030 Agenda for Sustainable Development

- In September 2015, the United Nations Sustainable Development Summit adopted the 2030 Agenda for Sustainable Development, which includes NCD-related targets as part of the Sustainable Development Goals (https://sustainabledevelopment.un.org/?menu=1300).

2002 Monterrey Consensus

- Since its adoption the Monterrey Consensus has become the major reference point for international development cooperation (http://www.un.org/esa/ffd/monterrey/MonterreyConsensus.pdf).

2008 Doha Declaration

The main highlights of the 2008 Doha Declaration (http://www.un.org/esa/ffd/doha/documents/Doha_Declaration_FFD.pdf) are as follows:
domestic resource mobilization: the importance of national ownership of development strategies and of an inclusive financial sector, as well as the need for strong policies on good governance, accountability, gender equality and human development;

mobilizing international resources for development: the need to improve the enabling environment and to expand the reach of private flows to a greater number of developing countries;

international trade as an engine for development: the importance of concluding the Doha round of multilateral trade negotiations as soon as possible;

external debt: the need to strengthen crisis prevention mechanisms and to consider enhanced approaches for debt restructuring mechanisms;

addressing systemic issues: the need to review existing global economic governance arrangements, with a view to comprehensive reforms of the international financial system and institutions.

World Health Assembly

Resolutions


World Health Report 2010 on health systems financing

- In this report, WHO maps out what countries can do to modify their financing systems so they can move more quickly towards universal coverage and sustain the gains that have been achieved: http://www.who.int/whr/2010/en/.
- Key concepts are summarized at http://www.who.int/health_financing/strategy/en/.

Regional resolutions and papers

Annex 2. Relationship of NCD financial mechanisms used in countries with recommendations from WHO GCM/NCD Working Group 5.1

<table>
<thead>
<tr>
<th>Country</th>
<th>Who</th>
<th>What</th>
<th>WG 5.1 recommendations</th>
</tr>
</thead>
</table>
| Thailand     | Government; various sectors      | 2% surcharge tax on tobacco + alcohol fund; Thai Health Promotion Foundation Source: Policy brief | 1. Mobilize and allocate significant resources to attain the NCD-related targets included in the Sustainable Development Goals by 2030, and the nine global voluntary NCD targets included in the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020  
2. Effectively and efficiently utilize and expand domestic public resources to implement national NCD responses, including by making greater use of revenue from tobacco and other health-related taxes to achieve national health objectives |
| Philippines  | Government; various sectors      | Tax increase by ~80% on tobacco + alcohol; used to increase population covered by national health insurance Source: Policy brief | 1. Mobilize and allocate significant resources to attain the NCD-related targets included in the Sustainable Development Goals by 2030, and the nine global voluntary NCD targets included in the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020  
2. Effectively and efficiently utilize and expand domestic public resources to implement national NCD responses, including by making greater use of revenue from tobacco and other health-related taxes to achieve national health objectives |
| Mexico       | Government                       | Additional 8% to 16% VAT (for domestic + imported products) on junk food (processed food) + sugary beverages to combat overweight and obesity Source: [http://gain.fas.usda.gov/Recent%20GAIN%20Publications/Mexican%20Junk%20Food%20Tax_Mexico%20TO_Mexico_4-9-2014.pdf](http://gain.fas.usda.gov/Recent%20GAIN%20Publications/Mexican%20Junk%20Food%20Tax_Mexico%20TO_Mexico_4-9-2014.pdf) | 1. Mobilize and allocate significant resources to attain the NCD-related targets included in the Sustainable Development Goals by 2030, and the nine global voluntary NCD targets included in the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020  
2. Effectively and efficiently utilize and expand domestic public resources to implement national NCD responses, including by making greater use of revenue from tobacco and other health-related taxes to achieve national health objectives |
| French Polynesia | Government                   | Taxes on sweetened drinks, beer, confectionery and ice cream Between 2002 and 2006, tax revenue went to a preventive health fund; from 2006, 80% has been allocated to the general budget and earmarked for health Source: World Cancer Research Fund International [http://www.wcrf.org/int/policy/nouri](http://www.wcrf.org/int/policy/nouri) | 1. Mobilize and allocate significant resources to attain the NCD-related targets included in the Sustainable Development Goals by 2030, and the nine global voluntary NCD targets included in the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020  
2. Effectively and efficiently utilize and expand domestic public resources to implement national NCD responses, including by making greater use of revenue from tobacco and other health-related taxes to achieve national health objectives |
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<tr>
<th>Country</th>
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<th>WG 5.1 recommendations</th>
</tr>
</thead>
</table>
| Hungary | Government  | Taxes on unhealthy products to be used to fund the national health care system | 1. Mobilize and allocate significant resources to attain the NCD-related targets included in the Sustainable Development Goals by 2030, and the nine global voluntary NCD targets included in the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020  
2. Effectively and efficiently utilize and expand domestic public resources to implement national NCD responses, including by making greater use of revenue from tobacco and other health-related taxes to achieve national health objectives |
| Barbados | Government  | 10% tax on sugary drinks; revenue from the tax will be directed to the health sector | 1. Mobilize and allocate significant resources to attain the NCD-related targets included in the Sustainable Development Goals by 2030, and the nine global voluntary NCD targets included in the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020  
2. Effectively and efficiently utilize and expand domestic public resources to implement national NCD responses, including by making greater use of revenue from tobacco and other health-related taxes to achieve national health objectives |
| Egypt   | Government  | Increased tobacco taxes with 46% (10 Egyptian piastres per pack of cigarettes) that is used to fund health insurance of students | 1. Mobilize and allocate significant resources to attain the NCD-related targets included in the Sustainable Development Goals by 2030, and the nine global voluntary NCD targets included in the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020  
2. Effectively and efficiently utilize and expand domestic public resources to implement national NCD responses, including by making greater use of revenue from tobacco and other health-related taxes to achieve national health objectives |
| Panama  | Government  | 2008, banned all promotion, sponsoring and advertising of tobacco; 2009, increased excise tax on cigarettes  
50% of tobacco tax revenues are used for health (National Institute of Oncology, Ministry of Health for cessation services, customs to fight illicit trade in tobacco products) | 1. Mobilize and allocate significant resources to attain the NCD-related targets included in the Sustainable Development Goals by 2030, and the nine global voluntary NCD targets included in the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020  
2. Effectively and efficiently utilize and expand domestic public resources to implement national NCD responses, including by making greater use of revenue from tobacco and other health-related taxes to achieve national health objectives |
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<th>WG 5.1 recommendations</th>
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<tbody>
<tr>
<td>Djibouti</td>
<td>Government</td>
<td>Increased tobacco taxes</td>
<td>1. Mobilize and allocate significant resources to attain the NCD-related targets included in the Sustainable Development Goals by 2030, and the nine global voluntary NCD targets included in the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020</td>
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<td></td>
<td></td>
<td>Spending programme on tobacco control</td>
<td>2. Effectively and efficiently utilize and expand domestic public resources to implement national NCD responses, including by making greater use of revenue from tobacco and other health-related taxes to achieve national health objectives</td>
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<tr>
<td></td>
<td></td>
<td>Source: WHO Technical Manual on Tobacco Tax Administration (pages 33, 133, 143)</td>
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<td></td>
<td><a href="https://books.google.ch/books?id=Lf4HtKQG02sCA&amp;pg=PA129&amp;lpg=PA129&amp;dq=earmarking+tobacco+taxes+DJIBOUTI&amp;source=bl&amp;ots=VOx1w611Po&amp;sourcex=bl&amp;ots=VOx1w611Po&amp;sig=rFzAipzml-77iK0SE&amp;hl=no&amp;sa=X&amp;ved=0CEcQ6AEwBGoVChM5d51pLjxwIVzDkUCH1_LgvTV#v=onepage&amp;q=djibouti&amp;f=false">link</a></td>
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<tr>
<td>United States of America</td>
<td>Navajo Nation (Arizona, Utah and New Mexico) semi-autonomous government</td>
<td>2% tax on “minimal-to-no nutritional value food items”</td>
<td>1. Mobilize and allocate significant resources to attain the NCD-related targets included in the Sustainable Development Goals by 2030, and the nine global voluntary NCD targets included in the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020</td>
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<tr>
<td></td>
<td></td>
<td>Amount per pack funds different types of activities, mainly health activities</td>
<td>2. Effectively and efficiently utilize and expand domestic public resources to implement national NCD responses, including by making greater use of revenue from tobacco and other health-related taxes to achieve national health objectives</td>
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<td></td>
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<td>Source: World Cancer Research Fund International</td>
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<td><a href="http://www.wcrf.org/int/policy/nourishing-framework/use-economic-tools">link</a></td>
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<td></td>
<td></td>
<td>and WHO Report on the Global Tobacco Epidemic 2015</td>
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<td></td>
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<td>[link](<a href="http://apps.who.int/iris/bitstream/10665/178574/1/9789240694606_eng.pdf?ua=1">http://apps.who.int/iris/bitstream/10665/178574/1/9789240694606_eng.pdf?ua=1</a> table 2.4)</td>
<td></td>
</tr>
<tr>
<td>South Africa</td>
<td>Discovery Health (health insurance company)</td>
<td>Cash back rebate programme (&quot;Vitality&quot;)</td>
<td>1. Mobilize and allocate significant resources to attain the NCD-related targets included in the Sustainable Development Goals by 2030, and the</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Source: Discovery Health</td>
<td>nine global voluntary NCD targets included in the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020. Effectively and efficiently utilize and expand domestic public resources to implement national NCD responses, including by making greater use of revenue from tobacco and other health-related taxes to achieve national health objectives</td>
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<tr>
<td>Tonga</td>
<td>Tonga Health Systems Support Programme</td>
<td>THSSP seeks to improve community health services and deliver preventative health measures. Source: <a href="http://dfat.gov.au/geo/tonga/development-assistance/Pages/development-assistance-in-tonga.aspx">http://dfat.gov.au/geo/tonga/development-assistance/Pages/development-assistance-in-tonga.aspx</a></td>
<td>1. Mobilize and allocate significant resources to attain the NCD-related targets included in the Sustainable Development Goals by 2030, and the nine global voluntary NCD targets included in the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020. 2. Effectively and efficiently utilize and expand domestic public resources to implement national NCD responses, including by making greater use of revenue from tobacco and other health-related taxes to achieve national health objectives. 3. Enhance policy coherence across sectors in order to ensure that the expected outcomes of national NCD policy are achieved, including by assessing the health impact of policies beyond the health sector.</td>
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<tr>
<td>Ghana</td>
<td>British United Provident Association (BUPA), MicroEnsure, Airtel</td>
<td>Pilot on a micro-insurance programme for health care for Airtel (mobile phone company) customers. Source: BUPA presentation <a href="https://www.google.ch/url?sa=t&amp;rct=j&amp;q=&amp;esrc=s&amp;source=web&amp;cd=1&amp;ved=0CB8QFjAAhUEwidg-ybwefHAhVHvRoKHSTPCE4&amp;url=http%3A%2F%2Fwww.aph.gov.au%2FDocumentStore.ashx%3Fid%3Df02268ee-cb09-41e4-a24b-927d260a31a3%26subId%3D253183%26usg%3DAFQjCNHYgJYJbwBnG3BHQ9KpmFrRA6FEQw">https://www.google.ch/url?sa=t&amp;rct=j&amp;q=&amp;esrc=s&amp;source=web&amp;cd=1&amp;ved=0CB8QFjAAhUEwidg-ybwefHAhVHvRoKHSTPCE4&amp;url=http%3A%2F%2Fwww.aph.gov.au%2FDocumentStore.ashx%3Fid%3Df02268ee-cb09-41e4-a24b-927d260a31a3%26subId%3D253183%26usg%3DAFQjCNHYgJYJbwBnG3BHQ9KpmFrRA6FEQw</a></td>
<td>1. Mobilize and allocate significant resources to attain the NCD-related targets included in the Sustainable Development Goals by 2030, and the nine global voluntary NCD targets included in the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020. 2. Effectively and efficiently utilize and expand domestic public resources to implement national NCD responses, including by making greater use of revenue from tobacco and other health-related taxes to achieve national health objectives. 3. Enhance policy coherence across sectors in order to ensure that the expected outcomes of national NCD policy are achieved, including by assessing the health impact of policies beyond the health sector.</td>
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<tr>
<td>Kenya, Nigeria, Ghana, United Republic of Tanzania</td>
<td>Medical Credit Fund (PharmAccess International)</td>
<td>Non-profit health investment fund; supports private health care facilities in Africa obtaining capital to strengthen and upgrade their operations in order to enhance access to affordable quality health care. Source: Medical Credit Fund (referred to in the summary report from the 2nd WG 5.1 meeting)</td>
<td>1. Mobilize and allocate significant resources to attain the NCD-related targets included in the Sustainable Development Goals by 2030, and the nine global voluntary NCD targets included in the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020. 2. Effectively and efficiently utilize and expand domestic public resources to implement national NCD responses, including by making greater use of revenue from tobacco and other health-related taxes to achieve national health objectives. 4. Promote and incentivize financing and engagement from the private sector to address NCDs, consistent with country priorities on NCDs. 5. Enhance policy coherence across sectors in order to ensure that the expected outcomes of national NCD policy are achieved, including by assessing the health impact of policies beyond the health sector.</td>
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<tr>
<td>Spain</td>
<td>British United Provident Association (BUPA), Valencian government</td>
<td>Public funding, public control, public ownership, private management for integrated care. Source: BUPA presentation and web pages.</td>
<td>1. Mobilize and allocate significant resources to attain the NCD-related targets included in the Sustainable Development Goals by 2030, and the nine global voluntary NCD targets included in the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020. 2. Effectively and efficiently utilize and expand domestic public resources to implement national NCD responses, including by making greater use of revenue from tobacco and other health-related taxes to achieve national health objectives. 4. Promote and incentivize financing and engagement from the private sector to address NCDs, consistent with country priorities on NCDs. 5. Enhance policy coherence across sectors in order to ensure that the expected outcomes of national NCD policy are achieved, including by assessing the health impact of policies beyond the health sector.</td>
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<tr>
<td>Indonesia</td>
<td>Government; Novo Nordisk</td>
<td>Establishing a national diabetes plan; access to screening, prevention and treatment for diabetes. 10% surcharge imposed on tobacco excise; at least 50% of its proceeds are allocated for health programmes and law enforcement at the regional level. Sources: Novo Nordisk <a href="https://www.novonordisk.com/content/dam/Denmark/HQ/Sustainability/documents/blueprint-changing-diabetes-in-indonesia.pdf">https://www.novonordisk.com/content/dam/Denmark/HQ/Sustainability/documents/blueprint-changing-diabetes-in-indonesia.pdf</a> and WHO Report on the Global Tobacco Epidemic 2015 <a href="http://apps.who.int/iris/bitstream/10665/178574/1/9789240694606_eng.pdf?ua=1">http://apps.who.int/iris/bitstream/10665/178574/1/9789240694606_eng.pdf?ua=1</a> table 2.4</td>
<td>1. Mobilize and allocate significant resources to attain the NCD-related targets included in the Sustainable Development Goals by 2030, and the nine global voluntary NCD targets included in the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020. 2. Effectively and efficiently utilize and expand domestic public resources to implement national NCD responses, including by making greater use of revenue from tobacco and other health-related taxes to achieve national health objectives. 4. Promote and incentivize financing and engagement from the private sector to address NCDs, consistent with country priorities on NCDs. 5. Enhance policy coherence across sectors in order to ensure that the expected outcomes of national NCD policy are achieved, including by assessing the health impact of policies beyond the health sector.</td>
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<td>Country</td>
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</tbody>
</table>
| Japan   | Government                   | Funds from social health insurance were used to fund health promotion activities | 1. Mobilize and allocate significant resources to attain the NCD-related targets included in the Sustainable Development Goals by 2030, and the nine global voluntary NCD targets included in the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020  
2. Effectively and efficiently utilize and expand domestic public resources to implement national NCD responses, including by making greater use of revenue from tobacco and other health-related taxes to achieve national health objectives  
4. Promote and incentivize financing and engagement from the private sector to address NCDs, consistent with country priorities on NCDs  
5. Enhance policy coherence across sectors in order to ensure that the expected outcomes of national NCD policy are achieved, including by assessing the health impact of policies beyond the health sector |
| Georgia | Universal health care         | Almost twofold expansion of budgetary allocation for health and reduced out-of-pocket payment | 1. Mobilize and allocate significant resources to attain the NCD-related targets included in the Sustainable Development Goals by 2030, and the nine global voluntary NCD targets included in the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020  
2. Effectively and efficiently utilize and expand domestic public resources to implement national NCD responses, including by making greater use of revenue from tobacco and other health-related taxes to achieve national health objectives  
5. Enhance policy coherence across sectors in order to ensure the expected outcomes of national NCD policy are achieved, including by assessing the health impact of policies beyond the health sector |
| Morocco | Government                   | Funds from social health insurance were used to fund health promotion and prevention activities | 1. Mobilize and allocate significant resources to attain the NCD-related targets included in the Sustainable Development Goals by 2030, and the nine global voluntary NCD targets included in the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020  
2. Effectively and efficiently utilize and expand domestic public resources to implement national NCD responses, including by making greater use of revenue from tobacco and other health-related taxes to achieve national health objectives |
Annex 3. NCD financing options: 13 country-level examples

### Domestic Taxation/Generate Resources: Thailand – Thai Health Promotion Foundation

Progressive health promotion funding mechanism for civil movements improving the well-being of Thai citizens by collaborating with all sectors of the society, from the national to the grassroots level.

<table>
<thead>
<tr>
<th>Type</th>
<th>Amount (Baht)</th>
<th>Sector</th>
<th>Geography</th>
<th>Year</th>
<th>Financing Gap</th>
<th>Funds Catalyzed (Baht)</th>
<th>Leverage (Public/Private/CS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic</td>
<td>2% 'surcharge' tax Health</td>
<td>Thailand</td>
<td>2001</td>
<td>Public/Private</td>
<td>100.6 billion</td>
<td>Public/Private/CS</td>
<td></td>
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</tbody>
</table>

**Why**
- Catalytic financial support for mechanism for health promotion activities, particularly in hard-to-reach areas for conventional bureaucratic system.
- The Health’s strategy has emphasized the concept of Triangle as the strategy to solve difficult social problems, by inter-linking strengthening the capacity of three interrelated sectors. These are: 1) creation of knowledge, 2) social movement and 3) political involvement.

**Who**
- **Principal and Partners**
  - High-level political support for this initiative, with TheHealth’s governing board chaired by the Prime Minister.
  - Half of the board members are from civil society organizations.
  - With its supporting role rather than replacing the existing bodies, TheHealth has incorporated extensive strategic partners from various sectors into networks to work synchronously.

**How**
- **Structures and Instruments Used**
  - Structure: Established a 2% surcharge on tobacco and alcohol excise would be earmarked to secure funding.
  - Core Elements: TheHealth promotes a wide range of activities (including tobacco and alcohol control, traffic injury management, promotion of physical exercise and sports for health, and promoting healthy eating).

**Insights**
- **Success and Lessons Learnt**
  - Public autonomous status allows TheHealth to facilitate and coordinate with partnerships across sectors and generate resources.
  - Funding mechanisms from both tobacco and alcohol sources could ensure the financial security.
  - Process to establish appropriate structure can be long so careful planning is required.
  - TheHealth’s complementary and coordinating role, rather than replacing, for existing structure/agency and capacity is widely viewed positively.

### Domestic Taxation/Generate Resources: The Philippines 2012 “Sin Tax Law”

Reformed excise tax on tobacco and alcohol used to improve health facility infrastructure and expand UHC to the poor.

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<thead>
<tr>
<th>Type</th>
<th>Amount (Peso)</th>
<th>Sector</th>
<th>Geography</th>
<th>Year</th>
<th>Financing Gap</th>
<th>Funds Catalyzed (Peso)</th>
<th>Leverage (Public/Private/CS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic</td>
<td>0.0</td>
<td>Health</td>
<td>Philippines</td>
<td>2012</td>
<td>Public/Private</td>
<td>5587 incremental funds in 2016 over 2013</td>
<td>Public</td>
</tr>
</tbody>
</table>

**Why**
- Highest rate of smokers in Southeast Asia and low cigarette prices.
- Lung cancer leading cause of cancer in the Philippines.
- Promote health by discouraging use.
- Collect more revenue/resources for the healthcare system.
- The aim is for the poorest 40% of the population to be covered through the ‘sponsored beneficiary’ program, either paid by local governments or from the ‘sin tax’ revenue of 15 million families to be covered through the program.

**Who**
- **Principal and Partners**
  - Department of Health
  - Department of Finance
  - PhilHealth – Philippine Health Insurance Corporation
  - Philippine Tobacco Farmers
  - Filipino population

**How**
- **Structures and Instruments Used**
  - Excise tax to discourage consumption - single excise tax structure on tobacco and alcohol. Annual indexing to avoid inflation erosion.
- Core Elements:
  - 15% of incremental revenues shared with tobacco farmers, 85% to the health budget.
  - Of the 85% remaining, 80% allocated for UHC and 20% nationwide for medical assistance and health facilities improvement.

**Insights**
- **Success and Lessons Learnt**
  - Introduction of an earmarking tax best made as part of an increase in an excise tax.
  - 5% increase in revenues from 2013 to 2014 – may be a challenge to sustain the incremental gains.
  - Expanded UHC to include 14.7m poor or near-poor families.
  - Significant drop in prevalence of poor smokers and 18-24 year olds.
  - Higher-than-expected collections invalidate allegations that the government is losing substantial revenues through illicit trade.

Sources:
- Philip devs.com/business/2014/12/18/1409183/sin-tax-collection-
- www.bbc.com/philippines/funding-nco-prevention-and-control-from-domestic-sources-
Domestic Taxation/Generate Resources: Botswana Levy on Alcoholic Beverages Fund

**Tax on alcoholic beverages finances nationwide campaign to reduce the harmful and negative impact on its society.**

<table>
<thead>
<tr>
<th>Type</th>
<th>Amount (SM)</th>
<th>Sector</th>
<th>Geography</th>
<th>Year</th>
<th>Financing Gap</th>
<th>Funds Catalyzed (SM)</th>
<th>Leverage (Public/Private/CIS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic</td>
<td>5% tax on alcoholic beverages</td>
<td>Health</td>
<td>Botswana</td>
<td>2008</td>
<td>Public</td>
<td>$150 by 2013</td>
<td>Public/Private</td>
</tr>
</tbody>
</table>

**Why**

**Rationale**

- Significant proportion of youth engaged in harmful consumption of alcohol.
- Social and health problems associated with consumption—alcohol-related violence, public disorder, road traffic accidents, criminal activities, risky sexual behaviors.
- Creation of a special fund “to promote projects and activities designed to combat and minimize the effects of alcohol abuse.”

**How**

**Structures and Instruments Used**

- 50% levy charged on alcoholic beverages finances the implementation of the country’s Alcohol Policy by using a multi-sectoral, multi-pronged approach to deal with the harmful and negative impact of alcohol.
- Core Elements:
  - Fund administered by multi-stakeholder implementation committee to support awareness, enforcement, and treatment programs.

**Insights**

**Success and Lessons Learnt**

- Evaluations have shown that increased prices have reduced consumption and enforcement of drunk driving laws decreased traffic accidents and fatalities.
- Auditor General reports revealed abuses of the use of the fund—better monitoring, evaluation and control of the levy implementation process required.
- Assessment of the health impact of the levy and policy implementation on society a challenge.


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Reduce Costs: Costa Rica - Universal Health Care and Social Security Insurance

**Financing healthcare via pooled compulsory insurance contributions.**

<table>
<thead>
<tr>
<th>Type</th>
<th>Amount (SM)</th>
<th>Sector</th>
<th>Geography</th>
<th>Year</th>
<th>Financing Gap</th>
<th>Funds Catalyzed (SM)</th>
<th>Leverage (Public/Private/CIS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic</td>
<td>0.0</td>
<td>Health</td>
<td>Costa Rica</td>
<td>1990s</td>
<td></td>
<td>0.0</td>
<td>Public/Private</td>
</tr>
</tbody>
</table>

**Why**

**Rationale**

- Goals are to:
  - Provide financial risk protection.
  - Improve access to health care.
  - Increase health outcomes.

**How**

**Structures and Instruments Used**

- Compulsory contributions from workers, the self-employed, enterprises and government are pooled into a single or multiple SHI funds to share the financial risk. Contributions are either flat rate or income-based and the government generally contributes on behalf of those who cannot.
- Core Elements:
  - Government determines what is covered and assures quality of care via its Public Health Policy.
  - Health care services are either provided by the SHI provider or via accredited public or private providers.

**Insights**

**Success and Lessons Learnt**

- Primary health care success story.
- Facilitating factors for the success of SHI include:
  - Level of income—individual ability to contribute.
  - Structure of the economy—highly informal economies are difficult to assess for contributions and administration.
  - Population distribution—easier to serve urban populations.
  - Country's ability to administer.
  - Level of solidarity in the society.
  - Government's stewardship—should ensure quality and appropriate coverage, including NCDs.
- Extending coverage to certain population groups is more difficult than extending to other groups—i.e., self-employed, casual, elderly.


---

22 countries have adopted social health insurance as part of their universal health care system, incl. Germany, Netherlands, ROE, Belgium

---

58
Reduce Costs: Universal Health Care - Mandatory Social Health Insurance (Indonesia)

Financing healthcare via compulsory employee insurance and gov't contributions.

<table>
<thead>
<tr>
<th>Type</th>
<th>Amount (SM)</th>
<th>Sector</th>
<th>Geography</th>
<th>Year</th>
<th>Financing Gap</th>
<th>Funds Catalyzed (SM)</th>
<th>Leverage (Public/Private/CS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic</td>
<td>0.0</td>
<td>Health</td>
<td>Indonesia</td>
<td>2014</td>
<td>Public/Private</td>
<td>0.0</td>
<td>Public/Private</td>
</tr>
</tbody>
</table>

**Why**

**Rationale**

- Goal is to achieve 100% basic health insurance coverage by 2019 (247 million people)
- Previous system covered the “poor” while the rich paid for private insurance but this excluded 60 million either not poor enough to qualify for government insurance or not rich enough to purchase private insurance.

**How**

**Structures and Instruments Used**

**Structure:**
- Those in formal employment pay a premium equivalent to 5% of their salary, with 4% payable by employers and 1% payable by employees. Informal workers, the self-employed and investors pay fixed monthly premiums of between 25,500 IDR ($2) and 50,500 IDR ($5) in a tiered system of first, second and third-rate care depending on the contributions they choose to pay.

**Core Elements:**
- Government determines what is covered and assures quality of care via its Public Health Policy.
- Single payer health care system.

**Who**

**Principal and Partners**

- Government sets policy and standards.
- Employers, employees, and government contribute.
- Social Health Insurance Fund provides financial and risk management.

**Insights**

**Success and Lessons Learnt**

- Highly informal economy complicates contribution assessment.
- Population and medical services distribution inconsistent.
- Administration difficult and administrative capacity low.
- In year one, achieved membership of 133.4 million, above target.
- Customer satisfaction is 81% and awareness of the new social health insurance system is 95%.
- Requires additional government investment to provide better quality services.

Reduced Costs: Universal Health Care – Mutual Health Organizations (MHOs) – (Rwanda)

Financing healthcare via community-based health insurance schemes.

<table>
<thead>
<tr>
<th>Type</th>
<th>Amount (SM)</th>
<th>Sector</th>
<th>Geography</th>
<th>Year</th>
<th>Financing Gap</th>
<th>Funds Catalyzed (SM)</th>
<th>Leverage (Public/Private/CS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic</td>
<td>0.0</td>
<td>Health</td>
<td>Rwanda</td>
<td>2014</td>
<td>Public/Private</td>
<td>0.0</td>
<td>Public/Private</td>
</tr>
</tbody>
</table>

**Why**

**Rationale**

Goals are to:
- Improve access to health care in a country with an informal sector of 90% of the population. In 2004, most facilities were unable and population couldn’t afford insurance coverage.

**How**

**Structures and Instruments Used**

**Structure:**
- Community based insurance schemes with sliding scale premium payments and no payment for the poor. Premiums are approximately 50/year complemented by 10% service fee.

**Core Elements:**
- Government determines what is covered and assures quality of care via its Public Health Policy.
- Community health workers and essential medicines nationwide.

**Who**

**Principal and Partners**

- Government to set policy and standards.
- Mutuelle de Sante insurance scheme.
- Village leaders and residents.
- Health services providers, especially community health workers.

**Insights**

**Success and Lessons Learnt**

- High degree of coverage and significant improvements in health.
- Over 90% health insurance coverage.
- Reduced out-of-pocket spending for health from 25% to 12% of total health expenditure.
- Significant increase in usage of health facilities.
- Best practices include: selection and management of delegated people; resource mobilization for granting microcredit for MHOs; legal framework for insurance; decentralization and separation of functions; human capacity development at all levels; mobilization of additional resources; community awareness; political leadership essential and has been very strong.
### Reduce Costs: MANISES Integrated Healthcare Model in Valencia, Spain

**Integrated PPP model for managing primary, specialized and long-term healthcare systems.**

<table>
<thead>
<tr>
<th>Type</th>
<th>Amount (SM)</th>
<th>Sector</th>
<th>Geography</th>
<th>Year</th>
<th>Financing Gap</th>
<th>Funds Catalyzed (SM)</th>
<th>Leverage (Public/Private/CS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic</td>
<td>$15bn</td>
<td>Health</td>
<td>Valencia, Spain</td>
<td>2000</td>
<td>Present</td>
<td>Public</td>
<td>7 Private/CS</td>
</tr>
</tbody>
</table>

#### Why: Rationale
- Poor operational and financial performance of the public system.
- Rising costs, ageing populations, and increasing patient demands for high-quality health services.
- Healthcare services can be more effective and efficient by focusing more on prevention and integrated care, which can be effective in producing better patient outcomes more cost-effectively.

#### Who: Principal and Partners
- Valencia Health Authority Government
- BUPA-Santitas
- Other important stakeholders:
  - Healthcare professionals
  - Valencia population in the Manises catchment area (approximately 200,000)

#### Insights: Success and Lessons Learnt
- Allows the government to predict annual healthcare expenditure.
- Two key success factors are the provision of value for money – in the Manises case, a high-quality, efficiency-focused health system, and stakeholder involvement and communication – especially existing healthcare professionals and the local population.
- 25% increase in efficiency.
- A long-term commitment is needed by all parties – government and private partners.

---

### Address Constraints: Singapore – Healthier Ingredient Scheme – coronary heart disease prevention through micro-subsidies for healthy food

**Government provides micro-subsidies to food suppliers to encourage food and beverage outlets to buy healthier oils.**

<table>
<thead>
<tr>
<th>Type</th>
<th>Amount (SM)</th>
<th>Sector</th>
<th>Geography</th>
<th>Year</th>
<th>Financing Gap</th>
<th>Funds Catalyzed (SM)</th>
<th>Leverage (Public/Private/CS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic</td>
<td>50</td>
<td>Public</td>
<td>Singapore</td>
<td>2015-2020</td>
<td>Private</td>
<td>$75 (↑)</td>
<td>Public</td>
</tr>
</tbody>
</table>

#### Why: Rationale
- High consumption of saturated fat from meals outside the home.
- Need to reduce incidence of coronary heart disease.

#### How: Structures and Instruments Used
- Investment of $5m in saturated fat intake reduction program through micro-subsidies to food suppliers who only supply healthier oils meeting certain criteria.
- Micro-subsidy covers the difference between the healthier and regular ingredients targeting 500,000 meals daily by 2020.

#### Core Elements:
- Food supplier submits grant application to HPBS detailing the type of oil it will use, current and projected number of F&B customers.
- HPBS provides grant and promotion support and monitors the grant with regular inspections and tests at outlets.

#### Insights: Success and Lessons Learnt
- Projected in 2-3% reduction in coronary heart disease incidence averting 1800 unhealthy life years in 2020.
- Projected economic benefits of $75M with an ROI >1100%.

---

Reduce Costs: PAHO Strategic Fund

A mechanism of purchasing medicines in bulk on behalf of participating countries to improve the availability, quality, and affordability of essential medicines

<table>
<thead>
<tr>
<th>Type</th>
<th>Amount (USM)</th>
<th>Sector</th>
<th>Geography</th>
<th>Year</th>
<th>Financing Gap</th>
<th>Funds Catalyzed (USM)</th>
<th>Leverage (Public/Private/CS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multilateral</td>
<td>7</td>
<td>Health</td>
<td>Latin America</td>
<td>2000 to present</td>
<td>Public</td>
<td>7</td>
<td>Public</td>
</tr>
</tbody>
</table>

**Why**

**Rationale**
- Ministries need support for improvement in areas of selection of quality products, financing, and procurement, cost containment, and intellectual property regulation, and supply management.
- High price of essential medicines inhibit access.
- Purchase decisions often based on price only leading to selection and use of inappropriate commodities.

**How**

**Structures and Instruments Used**

**Structures**
- PAHO provides technical assistance and pooled procurement for essential public health supplies to participating countries.
  (Includes NCDs)

**Core Elements**
- Account capitalized by 3% of the total cost of each purchase.
- Technical support for planning, supply, quality assurance and communication with global procurement initiatives.

**Who**

**Principal and Partners**
- Pan American Health Organization – Strategic Fund Group
- 24 Latin American Countries
- Collaborating Centers

**Insights**

**Success and Lessons Learnt**
- Creates economy of scale, lowering cost and improving leverage.
- Promotes capacity building.
- Requires strong political will and regional collaboration.
- Intellectual property challenges.

Address Constraints: Bilateral Funding – Health Finance & Governance (HFG) Project

USAID program that provides aid and technical support to 25 countries to strengthen domestic health financing and governance.

<table>
<thead>
<tr>
<th>Type</th>
<th>Amount (USM)</th>
<th>Sector</th>
<th>Geography</th>
<th>Year</th>
<th>Financing Gap</th>
<th>Funds Catalyzed (USM)</th>
<th>Leverage (Public/Private/CS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multilateral</td>
<td>$289M</td>
<td>15 LMICs</td>
<td></td>
<td>2012-17</td>
<td>Public/Private</td>
<td>0.0</td>
<td></td>
</tr>
</tbody>
</table>

**Why**

**Rationale**
- Need for good governance for health policymakers.
- Need for additional resources for universal health coverage.
- Need to improve country-owned health management and operations systems.
- Need for health systems performance and progress measurement.
- USAID’s Global Health Bureau launched the Health Finance and Governance (HFG) Project to support countries in their quest for stronger health systems.

**Who**

**Principal and Partners**
- USAID’s Global Health Bureau funds the HFG Project.
- Atz leads the project in collaboration with Avenir Health, Bread Branch, HAI, ITI, Johns Hopkins Bloomberg School of Public Health, DAI, Training Resources.
- 15 Low and Middle Income Countries receive bilateral aid, primarily in the form of technical support and assistance.

**Insights**

**Success and Lessons Learnt**
- Approaches must be country driven and customized based on country’s health care needs, resources, politics and leadership.
- Country ownership essential for sustainability and work towards universal health care.
- Examples:
  - Haiti: Supporting MOH with health management capacity building.
  - Namibia: Evaluation of its Development Fund for job creation and health insurance.
  - Ethiopia: Supporting introduction of national health insurance schemes with technical expertise and lessons learned from Ghana.

**Recyclable/Scalable?**

Y/N

**Overall project scalable but every country level project requires customization.**

Sources:
- HFG Project, USAID

61
Blended Finance/Generate Resources: Global Financing Facility for Every Woman Every Child
Mobilizes complementary financing for RMNCH to increase efficiency and reduce future resources needs.

<table>
<thead>
<tr>
<th>Type</th>
<th>Amount (SM)</th>
<th>Sector</th>
<th>Geography</th>
<th>Year</th>
<th>Financing Gap</th>
<th>Funds Catalyzed (SM)</th>
<th>Leverage (Public/Private/CS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Innovative</td>
<td>0.0</td>
<td>RMNCH</td>
<td>61 LICs &amp; LMICs</td>
<td>2015</td>
<td>Public/Private</td>
<td>0.0</td>
<td>Dom, Mult, IF</td>
</tr>
</tbody>
</table>

Why
Rationale
Global momentum exists to accelerate RMNCH, but challenges remain:
1) MDG 4 is an unfinished agenda; 2) Large funding gaps; 3) LICs shift to LICs and receive less funding; 4) Inefficient investments due to poor targeting of funds; 5) Poor civil registration and vital statistics systems.

The GFF has five objectives: 1) Finance national RMNCAH scale-up plans and measure results; 2) Support countries in the transition toward sustainable domestic financing of RMNCAH; 3) Finance the strengthening of civil registration and vital statistics systems; 4) Finance the development and deployment of global public goods essential to scale up; 5) Contribute to a better coordinated and streamlined RMNCAH financing architecture.

Who
Principal and Partners
- Domestic governments
- Multilateral and bilateral agencies
- Technical agencies
- Civil society
- Private sector
- Local population

How
Structures and Instruments Used
Structure: Mobilize USD 57bn by 2020 with complementary financing from domestic financing, GFF Trust Fund, IDA/IBRD and additional donor funds.
Core Elements:
- Heavily based upon mobilization of financing for comprehensive Country Investment Cases that provide detailed diagnosises and prioritization of needs and resource gaps by country.
- Health financing strategies and implementation.
- Global public goods development and deployment.
- Builds on existing structures with inclusiveness and transparency.

Insights
Success and Lessons Learnt
- New model to be introduced in 2015 –
  - $60bn pledged to date plus $3.2bn from IDA.
  - DRC, Ethiopia, Kenya and Tanzania to start 5-10 to follow.
- Lessons learned from the HRTTF model
  - Full integration with IDA/IBRD
  - Evaluation and monitoring

Innovative Finance/Generate Resources: International Finance Facility for Immunization (IFFIm)
Uses long-term pledges from donor governments to sell 'vaccine bonds' in the capital markets, making large volumes of funds immediately available for GAVI programs.

<table>
<thead>
<tr>
<th>Type</th>
<th>Amount (SM)</th>
<th>Sector</th>
<th>Geography</th>
<th>Year</th>
<th>Financing Gap</th>
<th>Funds Catalyzed (SM)</th>
<th>Leverage (Public/Private/CS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Innovative</td>
<td>?</td>
<td>Public/Private</td>
<td>Global</td>
<td>2006 to present</td>
<td>Public/Private</td>
<td>$6.5bn</td>
<td>Public/Private</td>
</tr>
</tbody>
</table>

Why
Rationale
- Extending immunization coverage requires long-term projects, such as health worker training for which developing countries need large scale, long-term funding.
- Created to rapidly accelerate the availability and predictability of funds for GAVI’s immunization programs.

Who
Principal and Partners
- IFFIm is a UK public charity managed by its board of directors.
- Donor governments: the United Kingdom, France, Italy, Norway, Australia, Spain, The Netherlands, Sweden and South Africa.
- World Bank – Treasury management
- GAVI – program implementation

How
Structures and Instruments Used
Structures:
- Sells bond on the international capital markets thereby increasing immediately available development funds, in exchange for expected long-term grant payments of its sovereign sponsors.
Core Elements:
- IFFIm issues AAA/Aaa-rated bonds in the international capital markets backed by donor countries.
- GAVI receives disbursements.
- World Bank manages bond proceeds as liquid investments until needed in recipient countries.

Insights
Success and Lessons Learnt
- Option for flexible financing of urgent/unforeseen needs – i.e. ebola vaccine.
- Demonstrated large appetite for investing in these types of mechanisms for development purposes.
- Brought in new types of capital e.g. institutional investors, high net worth individuals.
- IFFIm credit rating affected by market ratings of its donors which reduces ability to provide funding.
- Successful in keeping borrowing and admin costs low.

Sources:
- GAVI: World Economic and Social Survey 2012 in Search of New Development Finance, IFFIm.org

IFC15 - Yes, where front-loading is necessary, financing needs are temporary or investments self-financing in medium term, net resource costs, i.e. other vaccines, climate change adaptation, still renewable energy.
Blended Finance/Address Constraints: Medical Credit Fund (G-20 SME Finance Challenge Winner)

A non-profit health investment fund that supports private healthcare facilities in Africa obtaining capital to strengthen and upgrade their operations in order to enhance access to affordable quality healthcare.

<table>
<thead>
<tr>
<th>Type</th>
<th>Amount (SM)</th>
<th>Sector</th>
<th>Geography</th>
<th>Year</th>
<th>Financing Gap</th>
<th>Funds Catalyzed (SM)</th>
<th>Leverage Ratio (Private / Public)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Innovative Finance</td>
<td>22.5</td>
<td>Health</td>
<td>Africa</td>
<td>2009</td>
<td>Private</td>
<td>...</td>
<td>...</td>
</tr>
</tbody>
</table>

**Why**

- Clinics in private sector service 50% of the population yet have a hard time securing loans.
- Three Objectives: 1. Financial: the total available amount of capital for healthcare is increased, at a return for investors. 2. Clinical: achieved quality improvements are measured and evaluated according to international standards. 3. Social: more low-income people receive access to more improved healthcare services.

**How**

- **Structures and Instruments Used**
  - **Hybrid structures**: Grants finance the TA program and capital finances loans and guarantees and maintains limited default and currency risk facilities.
  - **MCF helps clinics draw a business plan, enroll in a quality improvement program, and connect to banks**.
  - **Risk sharing agreement with local banks in every country of operation**.
  - **Core Innovative Elements**: TA, local currency funding, strengthening investment climate.

**Who**

- **Investors and Partners**
  - **Donors**: USAID, Netherlands.
  - **DFIs**: OPIC, FMO, IFC.
  - **Foundations**: Calvert Foundation, Soros Economic Development Fund, Gates Foundation, Deutsche Bank Americas Foundation.

**Insights**

- **Success and Lesson Learned**
  - Capacity building through local public-private partnerships critical to ensure sustainability.
  - Measuring results for all partners is essential: clinical, social, and financial goals are set in place at the outset.
  - 968 clinics in program, with over 300,000 patient visits per month and nearly US$10m disbursed.
  - Enable clinics to alleviate resource constraints and improve quality, safety, and efficiency of their services.

Annex 4. National health subaccounts for NCDs: example of Democratic Republic of the Congo

National Health Accounts\(^{111}\) is a tool designed to assist policy-makers in their efforts to understand their health systems and to improve health system performance. They constitute a systematic, comprehensive and consistent monitoring of resource flows in a country’s health system for a given period and reflect the main functions of health care financing: resource mobilization and allocation, pooling and insurance, purchasing of care and the distribution of benefits.

This annex is specifically focused on expenditure on NCDs in the Democratic Republic of the Congo.

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current expenditure on Noncommunicable diseases (million US$)</td>
<td>33</td>
<td>35</td>
</tr>
<tr>
<td>Expenditure from government funding (%)</td>
<td>60%</td>
<td>35%</td>
</tr>
<tr>
<td>Expenditure from external funding (%)</td>
<td>10%</td>
<td>51%</td>
</tr>
<tr>
<td>Expenditure from private funding (%)</td>
<td>30%</td>
<td>14%</td>
</tr>
<tr>
<td>% total current expenditure</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>per capita in US$</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Pharmaceuticals % total current expenditure on Noncommunicable diseases</td>
<td>11%</td>
<td>22%</td>
</tr>
</tbody>
</table>

Annex 5. Data requirements for building the NCD investment case using the OneHealth Tool

The OneHealth Tool\(^\text{112}\) is a software tool designed to inform national strategic health planning in low- and middle-income countries.

While many costing tools take a narrow disease-specific approach, the OneHealth Tool attempts to link strategic objectives and targets of disease control and prevention programmes to the required investments in health systems. The tool provides planners with a single framework for scenario analysis, costing, health impact analysis, budgeting and financing of strategies for all major diseases and health system components. It is thus primarily intended to inform sectorwide national strategic health plans and policies.

The data required for costing an NCD plan using the OneHealth Tool are listed below.

**Data required for costing NCD plan using the OneHealth Tool**

<table>
<thead>
<tr>
<th>1. Intervention information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage data (note: default current coverage is present for all countries)</td>
</tr>
<tr>
<td>Current coverage</td>
</tr>
<tr>
<td>From survey data</td>
</tr>
<tr>
<td>From health information system</td>
</tr>
<tr>
<td>Target coverage over plan period</td>
</tr>
<tr>
<td>Agreed targets in action plan</td>
</tr>
<tr>
<td>Targets to attain Sustainable Development Goals</td>
</tr>
<tr>
<td>Population in need data (note: default data are present for all countries)</td>
</tr>
<tr>
<td>Based on epidemiology – how many people need the intervention</td>
</tr>
<tr>
<td>Survey data</td>
</tr>
<tr>
<td>Health information system</td>
</tr>
<tr>
<td>Global burden of disease</td>
</tr>
<tr>
<td>Review of interventions included in default package</td>
</tr>
<tr>
<td>Are all interventions there?</td>
</tr>
<tr>
<td>Review prices of drugs</td>
</tr>
<tr>
<td>Refer to essential medicine list</td>
</tr>
<tr>
<td>Refer to responsible persons for drug tendering</td>
</tr>
<tr>
<td>Review delivery mechanism</td>
</tr>
<tr>
<td>Particular attention on population-level interventions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Programme costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>These are the non-patient-level costs that are required to run the programme</td>
</tr>
<tr>
<td>Programme-specific human resources</td>
</tr>
<tr>
<td>Number of people employed in NCD-specific positions at national, regional and district level; Ministry of Health</td>
</tr>
<tr>
<td>Training plan</td>
</tr>
<tr>
<td>Number and length of training courses</td>
</tr>
<tr>
<td>Number of people to be trained</td>
</tr>
</tbody>
</table>

Training of trainers
Supervision visits from national to regional and district levels
Monitoring and evaluation costs
Transportation
Programme-specific vehicles
Communication, media and outreach
General – not intervention specific, which is included in section 1
Advocacy
General programme management
- Design and review of country strategy
- Development and review of annual work plan
- Development and review of human resource plan
- Programme coordination meetings
- Commodity regulation and policies
- Situation analysis

3. Health system costs

Human resources for health
- Number of staff employed within whole health system
- Review human resources for health plan
- Speak to human resources department of Ministry of Health to get numbers of staff currently employed
- Salary of staff
  - From human resources, current salary prices and expected growth

Infrastructure
- Number of facilities available
- Facility plan
- Number of beds
- Number of outpatient visits available
- Occupancy rates
- Construction costs for new facilities (not mandatory)

Data required for calculating the health outcomes associated with the NCD action plan

Epidemiological information (note: default data are present for all countries)
- Incidence, prevalence and mortality
  - From survey data
  - From mortality estimates
  - From registers

Intervention impact size (note: default data are present for all interventions where impact is well quantified)
- Impact sizes can be reviewed and changed

Data required for calculating the broader economic benefits associated with the NCD action plan
Global default data available for all data should country-specific data not be available.

GDP
- Labour force participation rate for country
  - From a local data source
  - Global defaults available from International Labour Organization (used as default data in model)
- Labour force participation rate for those with NCDs
  - Default data provided
Local data may be available

- Absenteeism rate for those with NCDs
- Presenteeism rate for those with NCDs
- Replacement time for people leaving the workforce


Annex 6. Selected results from the OneHealth Tool analysis of NCD costs and benefits: the case of Barbados

The financial resources required to implement the prevention and primary care activities in the Barbados Strategic Plan for the Prevention and Control of NCDs 2015–2019 totalled 56 million Barbados dollars in 2015, projected to increase to 97 million Barbados dollars in 2019.

This implementation aims to have a minimum return on investment of 1.9, meaning that for each 1 dollar spent, 1.9 dollars return is expected in economic growth. The costs of implementation are dominated by the drug and supply costs required for pharmaceutical prevention of cardiovascular disease and diabetes treatment (Table A6.1 and Figure A6.1).

Table A6.1 Interventions included as policy options for cardiovascular disease prevention and control in line with the WHO Global NCD Action Plan 2013–2020

<table>
<thead>
<tr>
<th>Tobacco control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Package warnings</td>
</tr>
<tr>
<td>Advertising bans</td>
</tr>
<tr>
<td>Cessation programmes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cardiovascular disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combination drug therapy for those at 30% or greater risk of a cardiovascular disease event over the coming 10 years</td>
</tr>
<tr>
<td>Drug therapy for those with SBP &gt; 160 mmHg, but total cardiovascular disease risk &lt; 30%</td>
</tr>
<tr>
<td>Drug therapy for those with total cholesterol &gt; 8 mmol/l, but total cardiovascular disease risk &lt; 30%</td>
</tr>
<tr>
<td>Aspirin post-acute stroke</td>
</tr>
<tr>
<td>Combination drug therapy for those with IHD</td>
</tr>
<tr>
<td>Combination drug therapy for those with stroke</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard glycaemic control</td>
</tr>
<tr>
<td>Intensive glycaemic control</td>
</tr>
</tbody>
</table>
It is estimated that an additional 73,000 person-hours is required in 2015, increasing to 127,000 additional person-hours in 2019, to deliver the Barbados Strategic Plan for the Prevention and Control of NCDs 2015–2019. This does not include the requirements for two additional full-time equivalent staff at the national administration level to implement additional NCD activities.

The economic return on investment due to increased workforce participation, reduced absenteeism and presenteeism, and reduced replacement costs are shown in Table A6.2. Return on investment is shown for both the 5-year period of the Strategic Plan and the 15-year Sustainable Development Goal period through to 2030. Avoided mortality is the greatest contributor to the GDP gains, which reach 17 million Barbados dollars in 2019 and 414 million Barbados dollars in 2030 due to this selected set of interventions. The total predicted GDP gain is 580 million Barbados dollars over the 15-year period, or 1% of annual GDP.
Table A6.2 Returns on investment for each Barbados dollar invested for selected policy actions in the Barbados Strategic Plan for the Prevention and Control of NCDs 2015–2019, and for the Sustainable Development Goal period to 2030

<table>
<thead>
<tr>
<th>Policy action</th>
<th>Return on investment: 5-year Strategic Plan</th>
<th>Return on investment: Sustainable Development Goal period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>GDP only</td>
<td>GDP + health returns value&lt;sup&gt;113&lt;/sup&gt;</td>
</tr>
<tr>
<td>Tobacco control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Package warnings</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Advertising bans</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Cessation programmes</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Cardiovascular disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Combination drug therapy for those at 30% or greater risk of cardiovascular disease event over the coming 10 years</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Drug therapy for those with SBP &gt; 160 mmHg, but total cardiovascular disease risk &lt; 30%</td>
<td>0.3</td>
<td>0.6</td>
</tr>
<tr>
<td>Drug therapy for those with total cholesterol &gt; 8 mmol/l, but total cardiovascular disease risk &lt; 30%</td>
<td>1.0</td>
<td>2</td>
</tr>
<tr>
<td>Aspirin post-acute stroke</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Combination drug therapy for those with IHD</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Combination drug therapy for those with stroke</td>
<td>18</td>
<td>20</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard glycaemic control</td>
<td>0.03</td>
<td>0.2</td>
</tr>
<tr>
<td>Intensive glycaemic control</td>
<td>0.1</td>
<td>0.7</td>
</tr>
</tbody>
</table>

Preventive interventions have a greater return on investment than treatment options for those who already have cardiovascular disease. Returns on investment for diabetes treatment are low, due to the high cost of treatment and low potential to increase labour force participation. For the preventive

<sup>113</sup> It is common when estimating the benefits of improved health to put a value on being alive, based on either the value of a life or the value of a year of life. Health benefits are thus non-market-valued health benefits, i.e. “intrinsic” health benefits like longevity and health-related quality of life. Consistent with the approach used by the Commission on Investing in Health and in the Inclusive Wealth Report’s national accounts for health capital, estimated longevity benefits were valued by applying an estimate of price deriving from data on wage differentials found between occupations of varying mortality risk.
interventions, the returns on investment continue to grow beyond the current 5-year Strategic Plan due to the long-term nature of the health outcomes.

**Conclusions**

Returns on investment vary across the range of interventions included in the analysis, due to the effectiveness and the costs of the interventions. For some interventions, such as combination drug therapy for cardiovascular disease, the full impact is yet to be seen in the 5-year Strategic Plan; thus, looking to the longer-term Sustainable Development Goal period provides important information when deciding on investment strategies.

It is clear from the analysis that a move towards increased preventive actions will yield a greater return on investment, based on the low cost of populationwide strategies, and greatest potential for change in workforce participation by preventing fatal and non-fatal events. Despite this, funds must still be available for treatment of cardiovascular disease and diabetes until the results of prevention activities begin to become apparent.
Annex 7. NCD financing options

The Working Group has discussed the level of funding needed to finance NCDs globally, and which sources should primarily cover that funding. The deliberations concluded that innovative financing instruments and, in a limited number of cases, external development financing may be an option for some countries to employ, in order to complement enhanced domestic financing. So-called innovative financing comes in many forms. The degree of innovation represented in the financing choices varies considerably – some have already been used in practice for many years. In the end, most countries will fund NCD-related activities from a blend of financing. Figure A7.1 provides a decision tree that countries might use in guiding their choice of reliance on the different options, and Figures A7.2 to A7.5 cluster financing options by country income levels.

Four different clusters of instruments can be identified:

1. There are high-volume instruments for poorer countries; their primary aim is to mobilize more public funds (Figure A7.2).

2. For developed countries, there is a group of instruments that are very effective and that can be used in a broad range of applications; all of these mechanisms are based on mobilizing additional private capital (Figure A7.3).

The use of instruments in both these clusters (Figures A7.2 and A7.3) should be actively considered and pursued, due to their focused effectiveness. In the centre, there is a broad palette of instruments – some designed to boost efficiency, other to mobilize private capital – that have an acceptable level of productivity, and that can also be used in a wide range of situations.

3. This set of instruments should be developed further in order to be put to use in the most suitable applications (Figure A7.4).

4. Finally, at the other end of the spectrum, instruments are shown that can raise high volumes of funds in very special circumstances (Figure A7.5). However, they cannot be used in a broad range of applications, and hence overall they have relatively little significance.

Viewed against the total volume of finance needed to address the global NCD disease burden, the innovative financing options shown here are promising, have increased in importance, and represent a significant amount of unused potential.
Figure A7.1 Flow chart of NCD financing options

Figure A7.2 High-volume instruments for poorer countries

GCM NCD Typology Landscape – options to be broadly explored

High volume, adequate range of application suitable for poorer countries; the aim is to mobilize more public funds
problems arise from unfavourable prevailing market conditions and from the uniqueness of some events
Figure A7.3 Mechanisms based on mobilizing additional private capital

Figure A7.4 Instruments suited to further development
Figure A7.5 Instruments that can raise high volumes of funds in special circumstances