WHO global coordination mechanism on the prevention and control of noncommunicable diseases

Working Group on how to realize governments’ commitment to provide financing for NCDs

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Policy Brief

Domestic financing for NCDs

by

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This policy brief is one of three relating to the commitment by Heads of State and Government at the High Level Meeting of the UN General Assembly on the Prevention and Control of Noncommunicable Diseases in September 2011 to explore the provision of adequate, predictable and sustained resources, through domestic, bilateral, regional and multilateral channels, including traditional and voluntary innovative financing mechanisms. A separate discussion paper summarises lessons learnt to date and possible approaches to support Member States to realize this commitment. All papers are available on the website of the WHO global coordination mechanism on the prevention and control of noncommunicable diseases (GCM/NCD) http://www.who.int/nmh/ncd-coordination-mechanism/en/.

This policy brief on domestic financing for Noncommunicable Diseases (NCDs) reviews key issues in current domestic financing for non-communicable diseases, options and challenges in increasing domestic financing for NCDs, and issues to consider in terms of optimising domestic funding for NCDs.

### Summary
- The costs of key health promotion and NCD prevention interventions are low.
- Although few data on domestic financing for NCDs in developing countries exist currently, there is limited government funding and a reliance on out-of-pocket payments in many cases.
- Slow progress in meeting commitments on domestic government funding of NCD prevention and control is likely to relate to the limited growth in government funding for the health sector in general; securing funds for new interventions or to expand existing ones is more likely when the health budget is increasing.
- There is scope for increasing government revenue in developing countries through improved revenue collection, increasing tax rates where these are low (including excise taxes on products with harmful health effects), introducing new taxes and maximising revenue from the exploitation of natural resources.
- Improved services for NCDs, as well as for other diseases and interventions for which additional funds are being advocated (such as HIV/AIDS, Tuberculosis (TB), maternal and child health) requires overall health system strengthening, particularly at the primary care level, and strategic purchasing of health services.

### 1. Key issues in current domestic financing for NCDs

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

Unfortunately, data on current levels of domestic financing for NCDs are almost non-existent, making it impossible to assess the extent to which developing countries are or are not devoting the requisite resources to NCD prevention and control. The main source of comparable data on health care financing is the WHO National Health Accounts (NHA) database. A growing number of developing countries are including disease-specific sub-accounts in their NHAs, which are then included in the WHO NHA dataset. However, these generally only include information on HIV/AIDS, malaria, TB and maternal and child health, probably because these diseases and groups are prioritised in the MDGs. WHO has advised countries to move away from sub-accounts for a limited number of diseases and to align with the 2011 System of Health Accounts and provide a comprehensive overview of the distribution of expenditure across disease categories. It is hoped that in future, information on expenditure on diabetes, cardiovascular diseases, cancers and other NCDs will be more readily available.

Despite the lack of data on domestic spending on NCDs, it is possible to comment in broad terms on the key sources of domestic financing in developing countries. Limited domestic resources, particularly government funding, are available for health services in developing countries. Traditionally, there has been an emphasis in developing countries on directing limited government funds to services for communicable diseases and maternal and child health services, partly due to the historical demographic and epidemiological profile in these countries but also to the advice of international organisations. In spite of 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.

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

2. Options and challenges in increasing domestic financing for NCDs

As reflected in the 2010 World Health Report, there is global recognition of the need for increased mandatory pre-payment funding for health services in developing countries, particularly tax and other government revenue, but which could be supplemented by mandatory health insurance contributions. Mandatory pre-payment funding is critical to reduce OOP payments and provide protection from their potentially catastrophic and impoverishing effects. While mandatory health insurance may generate additional funds for health services, it often only covers those in formal employment, contributing little to financial protection for the most vulnerable groups. Government revenue is, therefore, of critical importance. Voluntary health insurance is likely to have a very limited role in domestic funding of NCDs. Voluntary insurance is limited in most developing countries; it anyway focuses on curative rather than preventive interventions and is ill-suited to insuring against the costs of NCD treatment. Once an NCD is diagnosed, treatment costs are generally long term and predictable. For this reason, in a voluntary insurance environment there will be a tendency for those with NCDs to join insurance schemes (termed adverse selection), which will discourage relatively healthy individuals from joining a scheme. Insurance schemes often try to prevent adverse selection by excluding ‘pre-existing conditions’ from their cover, unless they are prevented from doing so through regulation. All of these factors lead to limited sharing of risk within voluntary insurance schemes. The rest of this brief does not consider OOP payments or voluntary insurance further.

1) General government revenue

There is growing pressure for increased domestic government funding for all health services, not only NCD-related interventions. In terms of the International Covenant on Economic, Social and Cultural Rights (ICESCR), every government has an obligation to make resources available to the maximum extent possible to realise the right to health care, education and other basic human needs. Thus, there is an expectation that individual nations must gradually take greater responsibility for generating domestic public revenue to fund health and other social services. A long-term goal that has been proposed by the recent Chatham House Working Group on Health Financing is that domestic government funding for health services should ultimately be at least 5% of GDP.
Overall government revenue and expenditure are relatively low in many developing countries. For example, while government expenditure in advanced economies is on average 45% of GDP, the average is less than 24% in low-income countries. However, there is a large range within each category of countries, with some low-income countries having government expenditure exceeding 50% of GDP, indicating that the level of government revenue and expenditure is not predetermined by a country’s level of economic development. Government revenue in developing countries can be increased by:

- Improving tax compliance and the efficiency of revenue collection. For example, revenue increased in South Africa through improving the management capacity of the revenue authority, changing the organisational culture to one of delivering a service and of zero tolerance for corruption, offering periods of amnesty for tax evaders to encourage compliance, and taking legal steps against those who remained non-compliant.
- Increasing tax rates where these are relatively low. Again, a country’s level of economic development does not predetermine its tax rates. For example, while Papua New Guinea and India have per capita GDP levels of less than $2,000, they levy amongst the highest taxes and social security contributions on personal income along with some of the highest income countries such as Luxembourg (with a per capita GDP level of $105,509), Denmark ($56,369) and Belgium ($43,593). This not only applies to direct taxes (such as personal income tax) but also indirect taxes (such as VAT and excise duties – see further discussion below).
- Introducing new taxes (such as financial transactions taxes).
- 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.

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’; to reduce transfer pricing by multinational corporations; and improve transparency around payments to developing country governments by extractive companies.
2) Excise taxes on products that are harmful to health

Within the context of NCDs, the emphasis in calls for increased government funding has been on increasing excise taxes on products with harmful health effects (so-called ‘sin taxes’), especially taxes on tobacco and alcohol products, given their public health benefits. There is extensive evidence that tobacco tax, and hence price, increases lead to a reduction in smoking. Studies in developing countries (e.g. Bolivia, China, India, Morocco, Nepal, South Africa, Sri Lanka) indicate that a 1% increase in price can lead to a reduction in smoking of between 0.3% and 0.8%\(^1\). In other words, if the price of cigarettes doubled, smoking rates could be reduced by as much as 80%. Best practices in maximising the public health benefits of tobacco taxation have been extensively documented by the WHO and others\(^1\).\(^2\).

In addition to the public health arguments, increases in these ‘sin taxes’ are favourably considered as they can generate considerable revenue in developing countries. For example, work undertaken for the 2010 World Health Report estimated that a 50% increase in excise tax on tobacco products would generate revenue equivalent to over 26% of government health expenditures in countries such as Madagascar and Viet Nam and over 50% in countries such as Laos\(^1\). More recently, the Lancet Commission on Investing in Health estimated that tax increases that raised the price of cigarettes by 50% in China would not only prevent 20 million premature deaths but also generate an extra US$20 billion tax revenue annually. The latest WHO estimates indicate that if all countries increased tobacco taxes by 50%, tax revenue would increase by US$101 billion globally\(^1\).\(^4\). The revenue generating potential could be even greater on alcohol products, given that excise taxes on alcohol tend to be lower than on tobacco products in most countries. An analysis of 42 countries (developing and developed) found that increasing excise duties on alcohol products to at least 40% of the total retail price would increase tax revenue in these countries by US$34 billion\(^1\).\(^1\).

There is growing discussion about introducing taxes on various foods and beverages (e.g. on refined, processed foods and sugar sweet beverages (SSBs)) that have harmful health effects. Such taxes are being implemented in countries like Hungary and Mexico. However, these taxes have not received as much support as taxes on tobacco and alcohol as there is presently a weak evidence base on the impact on health outcomes of these taxes, particularly in developing countries\(^1\)\(^1\).

Increases in so-called ‘sin taxes’ tend to receive greater public support when accompanied by interventions to support smokers to quit. Given the equity implications of these taxes, it is advisable to prioritise low-income communities for quit smoking support interventions and ensuring the availability of affordable healthy food in these communities.
3) To earmark taxes or not?

Some NCD control advocates have called for some or all of the revenue from ‘sin taxes’ to be earmarked or dedicated to NCD interventions. Traditionally any earmarking of tax revenue has been opposed strongly by Ministries of Finance, as it reduces their discretion in allocating government resources between the health and other sectors, particularly their ability to respond to changing government priorities. Even when overt opposition is overcome, earmarking of specific tax revenue may not translate into additional government funding for the health sector. Ministries of Finance often simply reduce allocations to the health sector from general revenues, so effectively displacing or offsetting the earmarked funding.

However, Ministries of Finance appear to respond positively to the public health arguments associated with these taxes. As there is a clear link between consumption (primary and secondary) of these goods and NCDs, a strong case can be made for earmarking these particular taxes to fund NCD interventions (referred to as the benefit principle), which is usually not the case with many other requests for earmarking of tax revenue.

A growing number of developing countries are succeeding in having some tobacco tax revenue (and less frequently alcohol tax revenue) earmarked for health services. These revenues are sometimes used for health services in general (e.g. Comoros, El Salvador, Guatemala, India and the Philippines) or for NCD specific interventions (e.g. the Oncologic Institute in Panama, cancer control in Nepal). Frequently, they are used for health promotion activities, which may be limited to tobacco control (e.g. Djibouti, Islamic Republic of Iran, Serbia, Tuvalu and Yemen) or may include other activities such as sports and recreation (e.g. Colombia, Estonia, Madagascar and Thailand). Box 1 highlights the contrasting experience of earmarking a portion of ‘sin taxes’ in two developing countries that are particularly noteworthy, the Philippines and Thailand. While Thailand introduced a small surcharge on tobacco and alcohol products to fund a highly successful, multisectoral health promotion foundation, the Philippines dramatically increased ‘sin taxes’ to fund increased mandatory health insurance coverage for the poor.

Box 1: Earmarking ‘sin taxes’ in Thailand and the Philippines

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<td>In 2001, an additional 2% ‘surcharge tax’ on tobacco and alcohol products was introduced, with the revenue being earmarked to fund the newly established Thai Health Promotion Foundation (ThaiHealth). ThaiHealth funds a wide range of multisectoral health promotion programs to the value of over US$100 million per year. Programs focus on tobacco and alcohol control, traffic injury management, promotion of physical exercise and sports for health, and promoting healthy eating. There is high-level political support for this initiative, with ThaiHealth’s governing board being chaired by the Prime Minister. Half of the board</td>
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members are from civil society organisations. ThaiHealth is widely regarded as a model for ensuring that health promotion activities receive adequate prioritisation, for supporting existing organisations (rather than creating parallel ones) and facilitating partnerships between government, the private sector, nongovernmental organisations and communities. It is seen as playing a “catalytic, coordinating, empowering and enabling role” for health promotion activities.\(^{15}\)

**Philippines**

Philhealth, a mandatory health insurance scheme, was introduced in 1995. It primarily covered formal sector workers and their dependents, although there was an effort to include vulnerable groups through a ‘sponsored beneficiary’ program, where local governments pay the contributions for these individuals. In late 2012, the ‘Sin Tax Law’ was passed, which dramatically increased excise taxes on tobacco and alcohol products. Most (about 80%) of the additional revenue generated was earmarked for the health sector, with the remainder being allocated to assist tobacco farmers who could face difficulties as smoking rates decline. Some of the earmarked health sector funds are used to improve health facility infrastructure, but the majority is used to pay Philhealth contributions for the poor. The aim is for the poorest 40% of the population to be covered through the ‘sponsored beneficiary’ program, either paid for by local governments or from the ‘sin tax’ revenue. It is anticipated that nearly 15 million families will be covered through this program. Thus, in the Philippines, ‘sin taxes’ are being used to support efforts to move to universal health coverage.\(^{16}\)

If earmarking is to be pursued, a key lesson from international experience is that often the earmarking relates to only a portion of tobacco (and sometimes alcohol) taxes, and frequently to the additional revenue generated from increasing these taxes or introducing a new element to these taxes (e.g. the 2% levy on tobacco and alcohol products in Thailand or the 2 paisa health tax per manufactured cigarette in Nepal). Resistance from Ministries of Finance to earmarking, and the likelihood of displacement of earmarked taxes, is reduced as this approach does not seek to earmark existing tax revenue. Similarly, Ministries of Finance are likely to be amenable to earmarking revenue from completely new taxes such as taxes on refined foods and sugar sweet beverages.

A drawback of earmarking certain tax revenue for NCD interventions is that it can contribute to the creation of vertical programs. However, a legitimate concern when funds are not earmarked but the focus is instead placed on increasing overall government revenue and ensuring that a fair share is allocated to the health sector, is that this will not necessarily translate into improved funding for the prevention and control of NCDs, particularly if NCDs are not seen as a priority by the Ministry of Health. This links to the possible reasons why only half of countries have met the goal of having an NCD prevention and control plan with a budget to allow for its implementation. These are likely to include factors such as the rigidity of the public sector financial management environment in some developing countries where
historical budgeting practices prevail. Once a pattern of distribution of resources between sectors and between facilities and/or services is established, it is difficult to break the historical inertia of these patterns. This is particularly the case when overall resourcing is not growing, because directing funds to a new activity or reprioritising budgets in favour of NCDs requires reducing budgets for other services. Resource allocation is a political process with forceful contestation for resources.

The ‘solution’ is not necessarily earmarking certain tax revenue for NCDs. Improved services for NCDs, as well as for other diseases and interventions for which additional funds are being advocated (such as HIV/AIDS, TB, maternal and child health) requires overall health system strengthening, particularly at the primary care level. It is opportune to interrogate transparently the value of continued contestation over limited government resources for disease-specific interventions, which are often conceived of in a vertical fashion. Strengthening comprehensive primary health care services and addressing the rigidities of public financial management practices are required.

In particular, there is a growing emphasis on the need to introduce strategic purchasing approaches in developing countries to ensure that the diverse needs of the population are met and that government policy priorities are implemented. The concept of strategic purchasing of services (not simply procurement of medicines and other supplies) was described as follows in the 2000 World Health Report: “Passive purchasing implies following a predetermined budget or simply paying bills when presented. Strategic purchasing involves a continuous search for the best ways to maximize health system performance by deciding which interventions should be purchased, how, and from whom.” It involves explicit prioritisation in specifying the range of services to be delivered in an integrated way, based on population health needs and cost-effectiveness considerations. Strategic purchasing is likely to be critical in ensuring that adequate government funds are devoted to NCDs, and for holding providers accountable for delivering the range of services needed by the population.

3. Key issues to consider in terms of optimising domestic funding for NCDs

The most likely reason for slow progress in meeting commitments to devote domestic government funding to NCD prevention and control in developing countries is the very limited growth in real (i.e. taking account of inflation) domestic public funding for health services in recent years, particularly in low and lower-middle income countries. A key strategy would, therefore, be to align calls for governments to meet their UN General Assembly commitments with advocacy for
increased government revenue for NCDs as well as other health interventions. Securing funds for new interventions or to expand existing ones is far more likely when government revenue is increasing.

It may be helpful to distinguish between population- and individual-level interventions when considering how to optimise domestic funding for NCDs. For population-level interventions, a convincing argument can be constructed for earmarking ‘sin taxes’, not only from a public health perspective, but also because these interventions require multisectoral action. An entity that can facilitate multisectoral engagement and involvement in NCD-related health promotion (such as ThaiHealth) would benefit from an earmarked revenue stream. The likelihood of success will be enhanced greatly if the earmarked revenue is additional to current government revenue, such as earmarking only that part of revenue derived from increasing tobacco taxes or from new taxes on harmful foods and beverages.

Dedicated taxes are not necessarily well suited to funding individual-level services, particularly the diagnosis and treatment of NCDs but even many preventive interventions for individuals, where these services are provided in an integrated way with other primary health care services. In these instances, very careful consideration must be given to what the perceived benefits of an earmarking approach would be, and earmarking should be compared with the alternative of supporting calls for increases in domestic public funding for health services overall and for introducing strategic purchasing arrangements to ensure that needs for NCD and other health services are met. To help inform this comparison, a key area for further research is the displacement effects of earmarking taxes for integrated, comprehensive health services, on which there is currently a weak evidence base. If these earmarked taxes are completely displaced by reduced allocations from general government revenue, commitments to increased prioritisation of NCDs are unlikely to be met.
References


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