



Health system financing architecture: Leverage the opportunities from investing in noncommunicable diseases

March 2026

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Executive Summary

Today, nearly two billion people globally are affected by noncommunicable diseases (NCDs), which are the leading cause of premature death, including cardiovascular disease, renal and metabolic diseases (such as diabetes), chronic respiratory diseases, cancer, and mental health conditions. To effectively change the clinical, economic, and societal trajectory of these diseases, we need to invest in healthcare at a systems level as well as in medicines and vaccines. This urgency is also reflected in the 2025 proposed United Nations (UN) political declaration on NCDs. The global economic burden of these diseases is growing — projected at USD 47 trillion in healthcare costs and lost productivity from 2010 to 2030. However, levels of public health spending are currently insufficient. A range of studies that project the financial requirements to achieve universal health coverage indicate that public health expenditure should be at least 5%–7% of GDP but it is far below this.

The case for investing in NCDs is clear and well established, as evidenced by the recently updated NCD “Best Buys” published by the World Health Organization. This is exemplified by the UN Interagency Task Force on Noncommunicable Diseases’ role in developing over 60 national investment cases that inform policy and financing decisions. According to research by Airfinity, commissioned by the International Federation of Pharmaceutical Manufacturers and Associations (IFPMA), almost five million lives could be saved annually if low- and middle-income countries invested 1% more of GDP in public healthcare spending, focusing on primary healthcare interventions for NCDs.

To advance the debate from a diagnosis of the issue to the implementation of a roadmap and address why NCDs programs, which demonstrate high levels of return, are not being supported with further investment, IFPMA commissioned Charles River Associates (CRA) to document case studies illustrating the investment case associated with NCDs, identify key enablers, and develop policy recommendations to scale up financing initiatives that support clinical, economic, and societal outcomes.

The research approach followed three key steps: (1) a literature review of qualitative and quantitative evidence, (2) an analysis of case studies where policymakers are prioritizing investment in NCDs to understand how the barriers had been overcome, and (3) interviews with stakeholders across nongovernmental organizations, academia, and experts from local pharmaceutical trade associations. The case study analysis covered financing mechanisms to increase resources available for NCDs (e.g., health taxes, debt swaps, development impact bonds, and insurance schemes).

Barriers to NCD financing included the following:

- Fragmentation in decision-making at the government level, that is, between Ministries of Health and Ministries of Finance on how to allocate budgets
- The prioritization of short-term spending and outcomes, whereas advancing a health system approach to NCDs often requires sustained investment
- The lack of public fiscal flexibility and associated political challenges in raising taxes, reallocating resources, or directing foreign aid
- Competing policy areas being prioritized at the expense of investing in health (e.g., resilience and security)

Drawing from the analysis, a series of concise policy considerations were developed that can support national-level governments to close the financing gap for NCDs when adapted for local contexts (Table 1).

Table 1: Policy considerations

1	Establish, review, or update long-term national plans with clear targets to address the growing NCD burden
2	Establish mechanisms to collect disaggregated data on spending and outcomes to inform preferred NCD interventions
3	Develop local investment cases that highlight the return on investment from investing in NCD prevention and care
4	Establish formal mechanisms to facilitate multistakeholder dialogue on health and fiscal policy priorities
5	Include health, particularly the prevention and management of NCDs, in related nonhealth policy planning and budgeting

1. Introduction

The need for greater and better investment in health, with a focus on investing in the prevention and treatment of noncommunicable diseases (NCDs), has been recognized as a healthcare priority globally. At the 78th World Health Assembly, countries adopted a resolution to improve public health spending and prioritize health in national budgets.ⁱ The resolution emphasized domestic government revenue as the primary financing source for healthcare, while acknowledging the role of external financing to strengthen health systems and achieve universal health coverage (UHC) under the Sustainable Development Goals (SDGs) agenda.

Investing in NCDs, which include cardiovascular diseases (CVDs), cancers, chronic respiratory diseases, diabetes, and mental health disorders, is central to achieving UHC. The proposed political declaration from the president of the United Nations (UN) General Assembly at the fourth high-level meeting on NCDs and mental health highlights the urgency of addressing these conditions.ⁱⁱ The declaration emphasizes a lack of progress toward the SDG target 3.4, which calls for a one-third reduction in premature mortality from NCDs by 2030 through prevention and treatment, reflecting a global desire to reduce the health and economic burden of NCDs.^{iii,iv} National governments have been developing national plans to address NCDs,^v and multilateral organizations, alongside the pharmaceutical industry, have called for greater investment in cost-effective NCD interventions.^{vi} Despite longstanding consensus on the need for action, a clear need to prioritize within health spending, and strong returns from high-value interventions, mechanisms for increasing funding remain unclear.

NCDs affect nearly two billion people globally, causing 17 million premature deaths annually, 82% of which occur in low- and middle-income countries (LMICs).^{vii,viii} The “big four” NCDs account for 80% of these deaths, with CVDs leading, followed by cancers, chronic respiratory diseases, and diabetes. Despite the magnitude of impact, NCDs and mental health conditions are estimated to receive only 1%–2% of global health financing.^{ix}

To investigate this issue and explore solutions, the International Federation of Pharmaceutical Manufacturers and Associations (IFPMA) commissioned Charles River Associates (CRA) to examine innovative financing mechanisms and lessons from successful case studies.

1.1 The global health investment gap in NCDs

Globally, the NCD burden is estimated to increase by 17% over the next 10 years, with the largest burden occurring in LMICs.^x Approximately 48% of NCDs in LMICs occur in individuals below the age of 70, compared to 28% in high-income countries (HICs). NCDs remain the leading cause of premature death and disability globally, and investments to address this remain insufficient. In 2011, the UN political declaration on NCD prevention and control announced a target to reduce the high mortality rates from CVDs, cancers, chronic respiratory diseases, and diabetes by 25%.^{xi} Yet as of 2025, these diseases remain responsible for 80% of all premature deaths related to NCDs.^{xii}

Despite evidence from recent research in LMICs showing that an additional 1% of GDP investment in total public healthcare expenditure—where 40% is channeled toward cost-effective primary NCD health care interventions like CVD management, diabetes screening, and respiratory care—could save close to five million lives each year, the recognition of the need to increase funding is less clear. Not all countries develop or report disaggregated data on NCD spending. However, national health accounts and diagnostic-related group data that are available suggest that although a significant share of health expenditures is directed toward managing NCDs, this is not growing as required. For example, in 2021, the Netherlands spent approximately US\$5,000 per capita on NCDs, which is about 70% of the nation’s total (public, private, and out-of-pocket) health spending.^{xiii,xiv} The available data suggests similar levels of spending in other HICs.^{xv} For example, a recent study of OECD countries found that average NCD

expenditure across these countries was US\$207 million per 100,000 population (or US\$2,070 per capita).^{xvi} However, even with this significant proportion dedicated to NCDs, it does not reflect the growth in demand for healthcare services.^{xvii} This is driven by increased demand for specialized treatments and long-term management of complex conditions, such as Alzheimer's disease.^{xviii, xix} As a result, countries face challenges in optimizing resource allocation and managing the growing financial pressure of NCDs.^{xx,xxi} There is a need for continued investment in innovation and strategic financing approaches that ensure spending translates into high-value and effective care.^{xxii}

In 2022, over 140 countries—impacting more than 80% of the world's population—invested less than 5% of GDP and less than 15% of their national budgets into health, two broad measures of the investment level to provide a minimum standard of healthcare. Among LICs, 48 spent more on debt interest than on health, while HICs are actively trying to increase public investment in defense and meet the ever-increasing demands on their healthcare systems.

The data on NCD funding is even more worrying in LMICs. The Lancet NCD Countdown 2030 estimated that LMICs require an additional \$18 billion in NCD spending per year over 2023–2030 to meet SDG targets.^{xxiii} Most NCD spending in LMICs comes from out-of-pocket (OOP) payments rather than through public or private insurance schemes. While most LMICs do not report disease-specific health accounts, OOP spending is estimated to constitute 74% of total NCD spending across the 11 African countries that do report spending on NCDs specifically.^{xxiv} This is particularly problematic given the chronic nature of NCDs and the long-term financial burden on households, leading to many people falling into financial crisis.^{xxv}

The investment gap is clear. Projections of the need for growth in health spending from public sources in OECD countries indicate that this growth will be twice the average growth in government revenues,^{xxvi} and various studies illustrate the need to close these gaps. In addition, it has been estimated that if LMICs were to invest an additional US\$1 per person per year on cost-effective interventions (including NCDs), seven million lives could be saved by 2030.^{xxvii} Alternatively, a 1% increase of GDP investment in total public healthcare expenditure in LMICs, where 40% of this is dedicated to primary NCD interventions, could save close to five million lives each year.^{xxviii}

1.2 Structure of the report

This report aims to explore the importance of increased financing and effective reallocation of resources to address the escalating pressures of NCDs globally, considering possible solutions and policy recommendations to address the mounting challenges for NCD financing across low-income countries (LICs), middle-income countries (MICs), and HICs. To do this, the remainder of the report is structured as follows:

- **Section 2** outlines the strength of the economic case for investing in healthcare and NCDs and examines whether there are barriers to effectively prioritizing investment into NCDs despite evidence of high returns, considering how each barrier manifests across countries of different income levels and the extent to which innovative financing mechanisms have been able to address those barriers.
- **Section 3** provides an in-depth exploration of the key learnings obtained from investigating current financing approaches for NCDs, including through reviewing a set of innovative financing mechanisms and speaking with experts representing distinct stakeholder groups.
- **Section 4** summarizes the key learnings from our research by presenting a set of succinct policy recommendations to bridge the financing gap in LICs, MICs, and HICs, which can be tailored and applied to specific contexts.

2. The financial case for investment and potential reasons why countries are not prioritizing NCDs

Investments in health must meet several requirements: they must deliver results to patients and their families; they must be affordable; and, if funded by taxpayers, they must represent a good use of taxpayers' money relative to other potential investments. Given the health investment gap and the increasing need to invest in NCDs, we need an economic rationale for investing in NCDs that should convince policymakers and ministers of finance.

2.1 A large body of evidence articulates a high return on investment for NCDs across low-, middle-, and high-income countries

One way of considering the economic case for investing in NCDs is to look at return on investment (ROI). There are different methodologies for calculating ROI in health, ranging from those that account only for monetary value (focusing primarily on healthcare costs) to those that include both economic and societal benefits.^{xxix,xxx} Across income settings, we found 13 papers over the last seven years documenting the ROI for the prevention and treatment of NCDs. Most of the literature emphasizes the broader societal value when estimating ROI for health interventions. This approach considers returns from the patient's perspective; the implications for the healthcare system, such as reduced long-term costs by addressing the root causes of NCDs; and the wider benefits to society, including increased labor market participation and improved economic productivity.^{xxxi,xxxii} Given the high economic burden associated with having one or more NCDs, particularly during one's most productive years, we focused on reports adopting wider economic implications in ROI calculations. Below we briefly review the extensive literature demonstrating the high ROI from addressing NCDs across LICs, MICs, and HICs, reinforcing the case for increased funding.

Evidence of ROI in low- and middle-income settings

Research from multilateral organizations such as the World Health Organization (WHO) has highlighted high ROI for NCDs in LMICs. For example, the WHO has identified cost-effective interventions, known as "Best Buys," for the prevention and control of NCDs, including interventions with a short-term payback (e.g., breast cancer: early diagnosis programs, HPV vaccination, among others).^{xxxiii} According to WHO estimates, every dollar invested in these measures can generate nearly seven dollars in social and economic returns.^{xxxiv} Furthermore, academic research reinforces high ROI in NCD prevention and control in LMICs (**Table 2**).

Evidence of ROI in high-income settings

In HICs, there is also strong evidence of high ROI for treating NCDs. For example, in HIC G20 countries, investing in 23 cross-sectoral policies to prevent and address NCDs was projected to yield \$2.7 trillion in economic benefits, with benefits outweighing costs 19-to-1.^{xxxv} The positive return when investing in NCDs holds for HICs across global regions (**Table 2**).

Table 2: ROI for NCDs across different studies

Author and study	Income setting	ROI
WHO (2021): "Saving Lives, Spending Less"	Low- and middle-income	US\$7 for every dollar invested in WHO "Best Buys" for NCDs
Troisi et al. (2024): "The Reported Impact of Noncommunicable Disease"	Low-income countries	US\$19 for every dollar invested in NCD interventions

Investment Cases in 13 Countries”		
Bertram et al. (2018): “Investing in Noncommunicable Diseases: An Estimation of the Return on Investment for Prevention and Treatment Services”	Low-income countries	3.8 benefit: Cost ratio for investing in cardiovascular disease
	Lower-middle-income countries	5.8 benefit: Cost ratio for investing in cardiovascular disease
	Upper-middle-income countries	20.2 benefit: Cost ratio for investing in cardiovascular disease
	High-income countries	3.8 benefit: Cost ratio for investing in cardiovascular disease
Spencer, Ostwald, and Thabrany (2023): “Investing in Health and the Economy: Curbing the Crisis of Noncommunicable Diseases”	High-income G20 countries	19-to-1 benefit-to-cost ratio for investing in 23 NCD cross-sectoral policies
Elmusharaf et al. (2022): “The Case for Investing in the Prevention and Control of Noncommunicable Diseases in the Six Countries of the Gulf Cooperation Council: an Economic Evaluation”	High-income Gulf countries	US\$4.9 for every dollar spent on NCD interventions
European Federation of Pharmaceutical Industries and Associations (2025): “The Case for Investing in a Healthier Future for the European Union”	High-income European Union countries (Portugal, Romania, Sweden)	€4.90 productivity gains for every €1 spent on breast cancer in Sweden €1.4 productivity gains for every €1 spent on diabetes in Portugal €1.1 productivity gains for every €1 spent on cardiovascular disease in Portugal

2.2 Why are the high economic and societal returns from investing in NCDs not leading to more investment?

Given the clear need for greater investment in NCDs from a Ministry of Health (MoH) perspective and the evidence of strong returns from a Ministry of Finance (MoF) perspective, there appears to be a compelling case for further investment. However, as set out in Section 1, the level of spending in HICs and LMICs does not appear to reflect this. Our literature review and the existing body of evidence identified a number of potential barriers that could affect the decision to invest in different countries. Unsurprisingly, how each barrier manifests and the barriers that are most significant depend on the country’s income level.

Barrier 1: A lack of communication between health and finance ministries and the need for reassurance regarding how investments in NCD programs can be tracked and/or how local evidence can strengthen an investment case.

While health ministries recognize the growing burden of NCDs, there is often a need to present a tailored financial case to ministries of finance, labor, employment, and development, as well as other relevant

government authorities. In some countries, limited coordination between ministries hinders progress, which may explain the G20's 2019 call for greater collaboration between finance and health ministries to achieve UHC.^{xxxvi} Earlier, in 2011, the OECD created the Joint Network of Senior Budget and Health Officials to support dialogue on the fiscal sustainability of health systems.^{xxxvii} This challenge affects both HICs and LMICs, though there may be particular concerns in LMICs about whether there is evidence of interventions working in the local context.^{xxxviii,xxxix} There are also concerns across countries of all income levels about whether interministerial dialogues are consistently taking place in practice.^{xl}

Barrier 2: Short-term investments in other policy areas outside of health are prioritized over sustained health investments.

Short-termism has been noted as a key issue in policymaking in many fields. In democratic governments, it is argued that policymaking timelines and continuity among decision makers are heavily influenced by political cycles; therefore, there is the need to demonstrate short-term impact. On many occasions, health investments take time to demonstrate economic benefits due to the complexity of system reforms but ultimately yield long-term benefits: improved health, greater workforce participation, and reduced future healthcare costs. Prevention programs and screening are good examples of interventions offering both immediate and long-term benefits. However, this long-term nature has been identified as a key barrier to effective investment.^{xli} For example, many parliamentary inquiries into health spending in the UK over the past two decades have highlighted short-termism as a key issue in policymaking.^{xlii, xliii} There is an ongoing debate regarding how future benefits or cost savings are taken into account (the discount rate) in healthcare decision-making.^{xliv}

In LMICs, short-term pressures and fragmented funding sources often crowd out the ability to make sustained investments, while in HICs there is currently increased pressure to reallocate resources toward other sectors (e.g., defense). In low-income and lower-middle-income countries, high debt repayment burdens create short-term pressures, and financing priorities are more likely to be driven by external donor priorities.^{xlv,xlvi} MICs may find themselves caught in the “middle-income trap,” where urgent fiscal pressures dictate reactive policymaking with limited incentives for structural reforms.^{xlvii} Countries should consider piloting multiannual budgeting frameworks for programs that inherently deliver benefits in the medium to long term to safeguard funding and budget execution while maintaining holistic budget oversight.

Barrier 3: Public budgets are strained, and investing in NCDs would require higher taxes,¹ greater borrowing, or reallocating money within the health budget—all of which are challenging.

In HICs, the demand for health services is increasing, leading to calls from various parts of the system for higher expenditure. However, the financial situation in many countries post-COVID is challenging. Leaving aside geopolitical pressures, economic growth is slow by historical standards, and levels of public debt are high. Often, the debate focuses on reallocating money within health budgets, but there are also calls for investment in other parts of the healthcare system, such as the labor force or aging hospital infrastructure. In addition, while there is an estimated 20% waste in the health systems in HICs, reallocating investments to reflect changes in healthcare needs is challenging—the focus on NCDs requires greater emphasis on primary care, early diagnosis, and a transition away from hospital-centric services. Furthermore, rigid financial architecture and strategies that predominantly center on acute care and do not support primary and community care, as well as early intervention with high-value medicines and other technologies, magnify the efficiency shortfalls in these systems.^{xlviii}

¹ For example, the WHO recently launched the “3 by 35” initiative to raise health taxes in an effort to save millions of lives. See WHO, “WHO Launches Bold Push to Raise Health Taxes and Save Millions of Lives,” July 2, 2025, <https://www.who.int/news/item/02-07-2025-who-launches-bold-push-to-raise-health-taxes-and-save-millions-of-lives>.

In LMICs, after initial progress, growth in public spending on health has stagnated.^{xlix} In LICs in particular, where international aid has historically accounted for a large share of health spending, official development assistance from HICs is currently falling, a trend that is projected to continue.^{li} Governments are also strained by other spending pressures. For example, in 2023, external debt of LMICs reached a record US\$8.8 trillion, meaning that 48 of these countries spend more public financing on repayments than on healthcare for their citizens.^{lii,liii}

Barrier 4: Competing demands mean that health is deprioritized given the need to focus on resilience and security.

While governments continue to be the main contributors to health spending in HICs, health expenditure as a percentage of GDP is declining following the COVID-19 pandemic, and other public priorities are emerging.^{liv} Notably, global military spending continues to rise, and NATO members recently committed to increasing defense spending to 5% of GDP.^{lv,lvii} Furthermore, as the threat of climate change escalates, countries are increasingly investing in clean energy technology to meet net-zero emission goals and ensure energy autonomy.^{lvii} Global energy investment is set to increase to a record of \$3.3 trillion in 2025, with national government funding being instrumental in kick-starting new projects.^{lviii}

While defense spending in LMICs is highly variable, in some countries it also continues to rise.^{lix} In 55 LMICs, OOP spending is the largest source of funding. Other areas of health system resilience, such as infectious disease management, continue to take priority over NCDs due to limited healthcare resources in some LMICs.^{lx}

2.3 Case studies to show how barriers can be overcome

Many countries around the globe are illustrative examples of good practices in promoting policies to tackle the burden of NCDs. A few include Colombia's ultra-processed food regulation and scale-up of a cervical cancer program, Jamaica's whole-of-government NCD approach, and South Africa's comprehensive 5x5 campaign.

To understand this further, we developed a series of case studies in which policymakers supported investment in NCDs. The aim was to assess the role of ROI evidence in decision-making, evaluate the significance of the hypothesized barriers, examine whether policies addressed these concerns, and identify key success factors in implementation. The analysis draws on public assessments, academic studies, and interviews with experts (**Table 3**). Given the focus on case studies where we could observe implementation and, ideally, outcomes, the case studies are necessarily historical. There are many more recent case studies for which it will be interesting to monitor progress.^{lxi}

Table 3: Barriers addressed in case studies

Case study	Geography	Relevant barriers addressed			
		(1) Limited MoF buy-in	(2) Short-termism	(3) Strained public budgets	(4) Rival policy demands
Tax reform and dedicated investment (tobacco and alcohol)	Philippines	✓		✓	✓
	Costa Rica	<i>No evidence identified</i>		✓	✓
Community-based health insurance schemes (CBHIs)	Rwanda	✓	✓		✓
Social health insurance reform	Kenya				✓
Addressing public debt (Debt2Health)	Cameroon–Spain; Indonesia–Germany; Indonesia–Australia		✓	✓	✓
New financial tools (development investment bonds)	India			✓	✓
	Cameroon			✓	✓

3. Key findings to bridge the financing gap

Although the case studies vary considerably in terms of geographical location and nature of the policy solution, it is possible to draw some common lessons (Annex 3) from these successful policy interventions, offering new insights to enrich the global discourse on effective financing approaches for NCDs.

3.1 The design and governance of financing mechanisms are critical to ensure success

Key success factors:

- **Dialogue between key stakeholders, particularly the MoH and MoF, to ensure sufficient funding commitments for healthcare**
- **Embedding ROI from health and population goals within economic development frameworks**
- **Policy embedded in a coherent, evidence-backed strategy aligned with political commitments and goals as well as a long-term national strategy beyond a given political cycle**
- **Partnership approaches facilitating multistakeholder efforts that can mobilize additional resources for health financing and support budget credibility**

Dialogue between key stakeholders, particularly the MoH and MoF, enables sufficient funding commitments for healthcare. In the Philippines, collaboration among the MoH, MoF, and presidential office was essential to advance a series of tax reforms (**case example 1**) that aimed to raise excise taxes on tobacco and alcohol, with technical and evidence-generating support from WHO and the World Bank.^{lxii, lxiii} Moreover, the MoF had clear goals that aligned with the proposed tax reform, including the earmarking of generated revenue for healthcare.^{lxiv} Through the reform, the MoF aimed to broaden the country's fiscal space to attract international investment and work toward achieving an investment-grade rating, which would help reduce borrowing costs.^{lxv} In 2019, a reform to further increase taxes on tobacco and alcohol was passed, supported by the development of a local NCD investment case by the UN Development Programme (UNDP) and the WHO in collaboration with the MoH (**case example 3**).^{lxvi} The case demonstrated the ROI of several policy packages, including the implementation of higher health taxes.^{lxvii} This effort was aligned with the WHO's recent "3 by 35" initiative, which calls for greater implementation of health taxes globally and urges countries to raise real prices on tobacco, alcohol, and sugary drinks by at least 50% by 2035.^{lxviii}

Case example 1: Philippines tax reforms

Overview

In 2012, the Philippines implemented the Sin Tax Reform, which increased health taxes on tobacco with the resulting revenue earmarked for health.^{lxix} Prior to the reform, tobacco taxes and prices in the country were low.^{lxx} Nearly 30% of adults used tobacco, and approximately 87,600 tobacco-related deaths occurred each year.

The Sin Tax Coalition, which included the MoF, MoH, Office of the Presidency, academics, civil society organizations, and multilateral institutions, jointly advocated for the reform.^{lxxi} The WHO and the World Bank provided analytical support, offering data on the health and economic burden of smoking, projected revenue gains, and estimated health impacts, which helped counter lobbying efforts from the tobacco industry.^{lxxii}

A key message from the Sin Tax Coalition was that the increased revenue would support the achievement of UHC.^{lxxiii} The reform allocated 80% of the revenue to expanding health coverage, advancing the Millennium Development Goals, and supporting health awareness programs.^{lxxiv} The remaining 20% was

directed toward improving healthcare infrastructure in underserved areas and providing support for indigent patients.

Impact

The Sin Tax Reform increased the average price of cigarettes in the Philippines from US\$0.42 in 2012 to US\$0.76 in 2017, representing an increase of more than 78%.^{lxxv} It also significantly expanded healthcare financing, nearly doubling the MoH's budget in its first year of implementation. In that first year alone, the tax generated over US\$1.2 billion and enabled the provision of healthcare services to an additional 45 million Filipinos.^{lxxvi} By 2015, the prevalence of tobacco use among adults had declined to 23.5%, representing a one-fifth reduction compared to its level in 2009.^{lxxvii} The Sin Tax Reform provides a legislated model of fiscal sustainability and revenue mobilization that tackles NCDs while scaling up UHC through earmarked financing.^{lxxviii}

Based on a report by the Task Force on Fiscal Policy for Health, taxes that generate a 50% increase in real prices of tobacco, alcohol, and sugary beverages would save 50 million lives over 50 years and could raise US\$3.7 trillion globally over just five years, including US\$2.1 trillion in LMICs. If allocated to health, this would increase government health care spending by 12% globally and by 40% in LMICs. These taxes are relatively quick to implement, reduce health systems costs, do not put economic growth at risk, and can thus help to alleviate current fiscal crises. A few examples include the bold action on tobacco taxes in Pakistan to save lives and raise revenues, the sustained action on alcohol taxes in Lithuania, and tobacco taxes in Ethiopia, which was part of a cross-parliamentary collaboration in framing the debate around health. While similar programs depend on each country's priorities and fiscal frameworks, those tax measures represent a financing approach that can be considered within a broader political environment.

In many countries, government ministries and key stakeholders continue to operate in silos, with limited collaboration and dialogue, particularly between the MoH and MoF,^{lxxix} which can limit effective advancement of solutions. In Indonesia, additional key stakeholders that drive health financing, such as the national development planning minister, are often not engaged in discussions.^{lxxx} This lack of coordination often results in health receiving insufficient attention in national budget allocations.^{lxxxi} To address this, continuous dialogue between these ministries is essential, and nongovernmental (NGO) stakeholders and international agencies can play a supportive role in facilitating and strengthening these discussions.

For example, in Kenya, the Principal Secretary for the Treasury is represented on the board of the National Health Insurance Fund, which allows for the continuous involvement of the Treasury in financing decisions.^{lxxxii} In such dialogues, highlighting financial outcomes that are important to finance ministers—such as ROI and economic impact—can help ensure stronger prioritization and more consistent funding for the health sector. In Rwanda, such dialogue between the MoF and MoH has resulted in increased budget allocation toward health to achieve economic and development goals (**case example 5**).^{lxxxiii}

Embedding ROI from health and population goals within economic development frameworks is also critical. One example is in Kenya, where a Financing Accelerator Network (FAN) Fund grant will support a locally identified need via the development of an economic modeling framework to quantify both the health and economic burden of major NCDs, assess current spending and financing gaps, and estimate the ROI of priority interventions.^{lxxxiv} The proposed framework will generate local evidence on the economic burden of NCDs, assess the cost-effectiveness of high-priority interventions, identify financing gaps, and quantify potential health and economic gains from more efficient investment. The results will support advocacy and policy dialogue for resource mobilization, budget planning, spending efficiency, and program design while ensuring NCD financing is integrated into Kenya's UHC agenda and national budgets.^{lxxxv}

Another example is in Rwanda, where its MoF incorporated health and population as a key sub-pillar within its Vision 2020 long-term economic development framework, which aimed to increase per capita income to the level of an MIC by 2020.^{lxxxvi} This inclusion underscored the recognition of the population as Rwanda's most valuable resource for future development, highlighted the critical link between health and poverty reduction, and highlighted that investment represented a high ROI for public funds. Consequently, Vision 2020 prioritized ensuring sufficient financial resources to achieve universal access to healthcare, positioning improved health outcomes as a vital strategy for reducing overall poverty (**case example 6**).^{lxxxvii, lxxxviii}

Goals and targets can play an important part in this process. The implementation of community-based health insurance (CBHIs) was accompanied by a strong and sustained commitment from the MoF to increase health financing, in line with the Abuja Declaration target of allocating 15% of the national budget to health by 2015.^{lxxxix} Remarkably, Rwanda is one of only three African countries to have consistently met or exceeded this target over the past two decades.^{xc} This success reflects the country's broader approach of embedding health goals within long-term, multisectoral development frameworks, which reduces the risk of fragmentation or shifting priorities due to political transitions.^{xcii}

Policy should be embedded in a coherent, evidence-backed strategy aligned with political commitments and goals. A comprehensive NCD policy can increase political momentum and governments' willingness to prioritize and allocate resources for NCDs. In Kenya, the MoH implemented a second NCD national plan for 2021–2026, which, unlike previous national plans, included a fully costed implementation plan enabling budget execution to inform resource mobilization efforts toward adequate financing for cost-effective NCD interventions.^{xciii} The plan prioritizes interventions with the highest impact, emphasizing multisectoral linkages, leveraging primary healthcare for integrating NCD prevention and care, increased coverage by insurance companies, and domestic financing for sustainability. Although financing challenges remain, Kenya has made progress toward increasing financing for NCDs through leveraging public-private partnerships, restructuring national health insurance, and exploring the implementation of health taxes.^{xciii} The newly established Social Health Insurance (SHI) scheme aims to increase coverage and work toward achieving UHC and has created a Primary Health Fund that earmarks budget allocations toward strengthening primary healthcare, including NCD screening and mental health services.^{xciv}

A broader example of this approach is the launch of FAN, which was co-created by a technical partnership between Access Accelerated, the World Bank, Results for Development, and other global and local partners. FAN aims to address critical gaps in financing for NCDs by bringing together global and local organizations to develop actionable financing solutions for NCDs, with a focus on supporting countries across sub-Saharan Africa, Latin America and the Caribbean, and Asia Pacific. FAN works via regional NCD Financing Accelerators that provide a structured platform for technical support (FAN Foresight), cross-country learning (FAN Forum), and catalytic seed funding (FAN Fund) as these efforts evolve. The FAN Accelerator for sub-Saharan Africa is the African Institute for Development Policy, an African-led, regional nonprofit research policy institute that bridges the gaps between research, policy, and practice in development efforts in Africa. For Latin America and the Caribbean, the FAN Accelerator is the Institute for Clinical Effectiveness and Health Policy (Instituto de Efectividad Clínica y Sanitaria), an independent, academic, nonprofit organization based in Buenos Aires, Argentina, dedicated to improving health policy and practice through research, evidence synthesis, and technical assistance in the region.^{xcv} Nevertheless, there remains a lack of comprehensive NCD policies across LMICs, creating difficulties in driving fiscal commitments for NCD strategies.^{xcvi}

Partnership approaches that facilitate multistakeholder efforts can mobilize additional resources for health financing and support budget credibility. In India, multiple stakeholders collaborated to finance initiatives aimed at improving the quality of maternal healthcare (**case example 2**).^{xcvii} Private

investors were incentivized to contribute capital, with the promise of repayment of the principal plus additional returns based on the achievement of prespecified health outcomes.^{xcviii,xcix} As a result, US\$2.9 million was raised to increase quality standards in maternal and newborn health, resulting in an estimated 13,499 averted deaths across 455 healthcare facilities.^c The impact bond successfully mobilized private capital and brought together multiple partners who would have otherwise worked in parallel. Therefore, although public funding is central to improved financing, this does not mean that other forms of financing cannot be part of the solution. Effective financing models can engage multiple stakeholders, including incentivizing the participation of private actors.^{ci}

Case example 2: Investing in maternal health in India

Overview

Rajasthan has some of the highest maternal and newborn mortality rates in India, with maternal mortality at 244 per 100,000 live births and newborn mortality at 47 per 1,000 live births in 2013.^{cii} These figures are significantly above the national average, with maternal mortality 47% higher and newborn mortality 14% higher than national levels. Each year, an estimated 80,000 babies die in the state.^{ciii}

Despite the fact that more than 25% of all deliveries occur in private health facilities, across all socioeconomic groups there has been limited attention given to the quality of care provided in these settings.^{civ,cv} To address this gap, a group of stakeholders designed a development impact bond (DIB) focused on improving maternal and newborn health outcomes in Rajasthan. The collaboration included the UBS Optimus Foundation as the investor, Palladium as the implementation manager, Hindustan Latex Family Planning Promotion Trust and Population Services International as service providers, and USAID and a pharmaceutical company as outcome funders.

The bond provided funding to the two service providers to support private health facilities in two key areas.^{cvi} First, they worked to improve the quality of care delivered to mothers and newborns. Second, they assisted facilities in preparing for certification under national quality standards, including the National Accreditation Board for Hospitals and Healthcare (NABH) and Manyata. The initial investors are repaid by the outcome funders based on results, specifically the number of private facilities that successfully meet defined standards for maternal and neonatal care.

Impact

Between 2018 and 2021, 405 out of 516 participating private health facilities were verified to have met national quality standards through NABH and Manyata certification.^{cvi} Modeling projected that achieving these outcome targets under a DIB would avert an estimated 13,499 maternal and neonatal deaths across the 405 facilities by 2023, representing a 44% reduction in deaths.^{cvi} Specifically, the model estimated that the quality improvements would save 12,221 neonatal lives, prevent 674 stillbirths, and save 554 maternal lives. Most of these lives saved were attributed to adherence to quality standards, particularly those related to improved case management during childbirth and postnatal care.^{cix}

3.2 Linking the investment in health to how the money is spent

Key success factors:

- **Transparency in addressing specific health-related goals that have broad public support with ongoing effort to monitor progress and impact**
- **Well-defined metrics and key performance indicators (KPIs), which can monitor progress and impact while also informing any necessary adaptations**

- **Allocating funds to high-value, evidence-based health interventions, which can reduce unnecessary health expenditures and inefficient spending on low-value healthcare provision**

Transparency in financing reforms that entail clear health-related goals, broad political consensus and will to earmark funding toward addressing key health care challenges as well as a clear communication campaign to the populations are critical to ensure success from a clinical, economic, and societal perspective.

The Philippines case example demonstrates the importance of including both the financing and how the money will subsequently be used in order to leverage greater resources domestically. In the Philippines, the tax reform generated over US\$1.2 billion in its first year alone.^{cx,cxi} However, unlike the example from the Philippines, many countries that impose health taxes do not earmark the revenue generated for healthcare, limiting its potential impact on health outcomes.^{cxii}

In addition to broad public support, transparency is particularly important when planning for budget execution and effective implementation. In the Philippines (**case example 1**), broad public support played a critical role in the successful implementation of the 2012 Sin Tax Reform Law.^{cxiii} Championed by the Sin Tax Coalition, the reform was framed as a means to generate sustainable funding for the country's pursuit of UHC.^{cxiv} The proposed bill earmarked revenues from increased excise taxes for health-related initiatives, allocating 80% to expanding coverage, supporting progress toward the Millennium Development Goals, and funding health awareness programs, while the remaining 20% was designated for improving healthcare infrastructure in underserved areas.^{cxv,cxvi} Despite challenges posed by the lobbying efforts of the tobacco industry, broad political and public support was achieved by focusing on health-related goals, which ensured successful implementation.^{cxvii,cxviii}

Well-defined metrics and KPIs can monitor progress and impact while also informing any necessary adaptations. While targets set by global organizations (SDGs and WHO) can play a role and set the direction, it remains the responsibility of countries to implement their strategies and specific plans linked to local funding and broader resources. Once innovative financing approaches are agreed upon, appropriate data collection is needed to ensure that investments are made into high-value interventions. The most formal applications of this approach are development impact bonds (DIBs), where the financial structure is designed around agreed-upon outcomes. While DIB mechanisms embed monitoring processes within the financing mechanism itself, other schemes also demonstrate the importance of ongoing monitoring. Rwanda's CBHI scheme was noted through reporting and monitoring to be financially unable to provide a sufficient number of services. This led to the government expanding the financial resources allocated toward CBHI to improve sustainability (**case example 6**).^{cxix}

Across LICs, MICs, and HICs, there may also be a concern about inefficient or poor oversight of implementation of new schemes.^{cxx} The challenge of responsible implementation can be seen by looking at Australia's National Disability Insurance Scheme, which has been characterized as being plagued by implementation challenges related to policy ambiguities, bureaucratic complexities, and cost concerns around budget sufficiency and execution.^{cxxi,cxxii} Australia's Royal Commission into Aged Care Quality and Safety also identified this challenge, whereby there was a proliferation of underqualified and underresourced providers receiving payments through the scheme, leading to low-value, substandard, and neglectful care.^{cxxiii,cxxiv} Metrics to demonstrate the efficient use of public money can be as important as improvements in health outcomes in reassuring that the scheme is proceeding as planned.

Allocating funds to high-value, evidence-based health interventions can reduce unnecessary health expenditures and inefficient spending on low-value healthcare provision. Investment cases for NCDs in LMICs grounded in their social and economic costs have been developed for several countries in partnership with international agencies such as the UNDP (62 countries, 92 national investment cases on health issues; see **case example 3**).^{cxxv,cxxvi} The UN Interagency Task Force on Noncommunicable

Diseases has worked on 32 projects globally. These investment cases aim to guide policymaking by demonstrating the significant health and development costs of NCDs and showcasing the availability of cost-effective interventions to offset costs in the local context.

The availability of local evidence of ROI generated by the UNDP investment cases has been seen as pivotal in leading to policy action.^{cxxvii} However, to implement a greater number of recommendations set out in these cases, additional actions must be taken to address persistent barriers, including shifting political priorities and changes in political leadership.^{cxxviii}

Case example 3: UNDP investment cases for health financing

Overview

Investment cases for NCDs in LMICs assessing their social and economic costs have been developed for several countries in partnership with international agencies such as the UNDP.^{cxxix} These investment cases aim to guide health policy by demonstrating the significant health and development costs of NCDs and showcasing the availability of cost-effective interventions to offset costs in the local context.

Impact

Since 2016, at the request of governments, the UNDP and WHO have developed 92 investment cases.^{cxxx} Of these, an aggregate analysis across 13 countries (Armenia, Barbados, Cambodia, Ethiopia, Jamaica, Kyrgyzstan, the Russian Federation, the Philippines, Thailand, Turkey, Uganda, Uzbekistan, and Zambia) found a projected return of US\$19 for every dollar spent toward NCDs in LICs.^{cxxxi} This analysis complements the findings of other studies; for example, the Lancet NCD Countdown 2030, according to which a global investment of US\$18 billion in NCDs per year would result in a global benefit of US\$2.7 trillion by 2030.^{cxxxii}

In the Philippines, at the request of the government, the WHO and UNDP developed a national investment case for NCDs.^{cxxxiii} The study found that in 2017, NCDs were responsible for 68% of all deaths and imposed an economic burden of US\$14 billion, equivalent to 4.8% of the country's GDP.^{cxxxiv} The investment case demonstrated the ROI of investing in various policy packages, including measures targeting tobacco and alcohol use, promotion of physical activity, salt reduction, and clinical interventions for CVD.

In response to the findings and in line with UNDP recommendations, the Philippines increased tobacco taxes earmarked for the expansion of UHC.^{cxxxv} The government also introduced several national health strategies, identifying NCDs as a key priority. Additionally, recognizing the growing need for mental health services, the Philippines requested support to develop a local investment case for mental health, emphasizing its value to the overall health system.^{cxxxvi}

Another innovative approach to healthcare financing is the Debt2Health (D2H) swap program (**Case example 4**). This also prioritizes funding for programs that clearly outline expected outcomes, drawing on evidence or pilot successes to demonstrate cost-effectiveness and value.^{cxxxvii} Rather than financing "stand-alone" programs in beneficiary countries, D2H funds are directed to ongoing, local programs aligned to the advancement of SDG goals and the country's overall health strategy.^{cxxxviii, cxxxix} This ensures that investments not only deliver health impact but also reinforce existing political and policy priorities, leading to reduced fragmentation.^{cxli}

Case example 4: Global Fund's Debt2Health program

Overview

The Debt2Health (D2H) scheme by the Global Fund converts debt repayments into investments in measurable, results-driven health interventions in LMICs.^{cxlii} The primary goal of D2H swaps is to mobilize

additional resources for health in LICs and MICs with limited healthcare budgets and significant debt repayment pressures.^{cxlii} Through this arrangement, the Global Fund facilitates agreements in which implementing countries commit to invest in additional health programs, while donor countries receive indirect benefits and cancel a portion of the debt owed to them.

Funds generated through D2H swaps are directed to existing grants or programs managed by the Global Fund that align with SDG goals and national health strategies.^{cxliii} These programs reflect the Global Fund's investment priorities, with most D2H initiatives focusing on infectious diseases, such as malaria and tuberculosis, and more recently on strengthening overall health systems.

Funding is provided through a performance-based model, where continued support depends on achieving agreed-upon targets.^{cxliiv} Program implementation is monitored through established governance structures at both the Global Fund and country levels, involving civil society, the private sector, the government, and patient advocacy groups.

Impact

From 2007 to 2021, the Global Fund coordinated 12 D2H transactions that generated over US\$226 million in health funding for 10 debtor countries.^{cxliv} For example, in the Spain–Cameroon D2H agreement, Cameroon invested US\$9.3 million into its HIV/AIDS program, allowing an additional 30,000 people living with HIV to obtain access to treatments, while Germany and Indonesia signed a landmark €75 million Debt Conversion Agreement to Strengthen Public Health, which represents the largest D2H swap to date and will significantly enhance Indonesia's ability to combat infectious diseases and strengthen its health systems.

While investment cases are a helpful starting point to demonstrate the value to policymakers in the local context, trade-offs and efficiencies must be considered. To optimize this, investment cases should be developed with consideration of allocative efficiency, optimizing the value of NCD financing across the different services that need to be provided.^{cxlvi} By tackling inefficiencies simultaneously with new investments, countries amplify the impact of every dollar spent. Similarly, DIBs embed the financial reward within the payment model. Another innovative financing scheme in Cameroon focused on cataract surgeries that were selected as the focus of the DIB due to their cost-effectiveness and clearly measurable outcomes (**case example 5**).

Case example 5: Cameroon cataract DIB

Overview

A report commissioned and funded by the Fred Hollows Foundation highlighted the lack of sufficient financing for eye care as a major barrier to eliminating avoidable blindness in LMICs.^{cxlvii} Cameroon was selected as a focus country after findings revealed that without systemic changes in eye care delivery, the number of avoidable blindness cases was projected to double by 2020.^{cxlviii} Avoidable blindness can be caused by aging and NCDs, such as diabetic retinopathy, glaucoma, and age-related macular degeneration.^{cxlix} Cataract surgery is a widely recognized, cost-effective procedure with clearly measurable outcomes and demonstrated links to improved socioeconomic well-being.^{cl}

In response, the Fred Hollows Foundation led the Cameroon Cataract Bond initiative. The initiative aimed to provide US\$2 million in financial support for the operational costs of a new hospital, Magrabi ICO Cameroon Eye Institute (MICEI), without the need to repay loans.^{cli} The initiative also aimed to leave a financially sustainable hospital in place after five years that could serve as a regional training institute for the Central African Economic and Monetary Community region. To that end, outcome targets for the impact bond were defined in close consultation with the MICEI management team, ensuring alignment with national priorities and local health system capacities.^{clii}

Impact

After three years, the hospital had performed 6,374 cataract surgeries, surpassing the original target of 5,600.^{cliii} MICEI also exceeded its quality target, with 815 surgeries resulting in a good outcome the day after surgery, well above the minimum benchmark of 50%.^{cliv}

Despite these successes, one of the major challenges of the cataract bond was securing investor participation, for example, the US Overseas Private Investment Corporation and the Netri Foundation.^{clv} Some prospective investors declined to join the project, citing a misalignment with their geographic or programmatic priorities, while others were hesitant due to the perceived risks associated with results-based health investments.

3.3 Investing in NCDs is a complement to other priorities

Key success factors:

- **Broader health system resilience, particularly in LMICs but also in HICs, can support investments in health overall**
- **Evidence on how health contributes to economic goals, improving economic productivity and contributing to growth**
- **The role of healthcare in terms of political priorities—link to defense and to climate transition**

Broader health system resilience, particularly in LMICs but also in HICs, can support investments for NCDs and enable improved access to medicines. Although historically the focus on health financing in LMICs was toward infectious disease, this has evolved in recent years. More recently, these priorities have been broadened to include investments in the building of resilient and sustainable health systems, which would have benefits for infectious diseases as well as NCDs.^{clvi} Improving health systems capacity—such as through improved procurement and supply-chain mechanisms or health system infrastructure and workforce training—can also facilitate access to medicines for NCDs.^{clvii,clviii} The significant investments that have been made, and that are continuing to be made, in infrastructure and programs to prevent and treat infectious diseases in LMICs could also be leveraged through an integrated approach to improve access to medicines and care for NCDs, particularly at the level of primary care.^{clix}

Timely treatment of NCDs limits disease progression and reduces severity of symptoms (particularly relevant for high-cost systems), minimizing any disruptions to work and improving economic participation of individuals.^{clx} There is evidence that policymakers recognize this. While Rwanda's CBHI scheme (**case example 6**) provided some access to essential medicines provided at eligible health centers and hospitals, in July 2025 this was expanded with the announcement that the CBHI scheme would provide reimbursement for cancer treatment to all covered patients.^{clxi}

Case example 6: Rwanda's CBHI scheme

Overview

In 2000, Rwanda's MoF developed Vision 2020, a long-term economic development framework.^{clxii} Health and population were identified as key components of this strategy, emphasizing the country's population as its most valuable resource and recognizing the close link between poverty and health. One of the central goals of Vision 2020 was to ensure sufficient financial resources to achieve universal access to healthcare.

To advance this goal, Rwanda introduced CBHI schemes in 2004 as an integral part of the national health financing system.^{clxiii} The objective was to expand access to healthcare services, protect households from health-related financial hardship, and support sustained population health as a driver of economic progress.

CBHI schemes are structured as partnerships between communities and healthcare providers. In alignment with Rwanda's broader decentralization policies, the schemes are managed at the district level,

with directors and auditors appointed by the MoH.^{clxiv} In 2007, enrollment in CBHI became mandatory for all Rwandans not covered by another insurance arrangement, such as military or private health insurance.^{clxv}

Household contributions to the CBHI scheme are determined based on income level, following Rwanda's Ubudehe classification system.^{clxvi} Individuals in category 1, representing the lowest wealth quartile, are fully subsidized by the government or external donors and are not required to pay premiums or copayments. CBHI covers a wide range of services and medicines provided at health posts, health centers, district and provincial hospitals, as well as referral hospitals.^{clxvii} The MoH and the Rwanda Social Security Board have jointly defined the list of medical procedures and essential drugs eligible for reimbursement. The benefits package includes outpatient and inpatient care, essential medicines, diagnostic imaging, and laboratory tests.

Impact

The introduction of novel CBHIs in Rwanda proved highly successful. A 2012 report on the implementation of Vision 2020 found that life expectancy increased from 51 years in 2002 to 64 years by 2012, partly due to improved access to health services.^{clxviii} By 2018, Rwanda had the highest health insurance enrollment in sub-Saharan Africa, and by 2019, it had achieved most of the UHC prerequisites, except for remaining systemic barriers.^{clxix} Furthermore, CBHIs also contributed to a significant reduction in OOP spending, lowering it by about 3,600 Rwandan Francs (US\$12), or 83% of the average per capita healthcare expenditure compared to 2000.^{clxx} Other examples include Ethiopia's CBHI initiative that was set up as a community-based health project that gathers payments made by members into a fund, which covers basic health care costs; thus, members are enabled access at local health care centers whenever they are sick. CBHI stems from the Ethiopian MoH's effort to reach UHC by improving overall financial protection for healthcare.

Evidence exists on how health contributes to economic goals, improving economic productivity, and enhancing growth. The broader literature provides evidence on this point. The cost of ill health globally was more than \$12 trillion in 2017 (around 15% of real GDP), while better health could add US\$12 trillion to global GDP in 2040, representing an 8% boost that translates into 0.4% faster growth every year.^{clxxi} In the UK, one analysis found that for every £1 spent per person on the NHS, there is a corresponding ROI of £4 to the broader economy.^{clxxii} As Section 2.2 illustrates, there is significant evidence of economic returns, including to productivity, from investing in NCDs.^{clxxiii, clxxiv} In Rwanda, health and population was included as a sub-pillar of its economic Vision 2020 strategy (**case example 6**).^{clxxv} In 2020, an evaluation of the scheme found that CBHI reduced the risk of financial catastrophe by approximately 20%.^{clxxvi} Countries can also look for opportunities to link their financing approaches to broader economic goals. For example, while the 2012 Sin Tax Reform in the Philippines was implemented primarily as a health measure it was also the ability to secure an investment-grade sovereign debt rating through improved tax and expenditure policies was also considered to be an additional benefit.^{clxxvii}

Prioritizing healthy populations has important implications for other areas of government policy priorities, including those pursued in HICs The health system provides a critical foundation to enhance the social and economic infrastructure importance for addressing all other policy priorities (e.g., unemployment, healthy aging) and is increasingly operating as the first layer of defense against global threats, including climate change and threats to national security.^{clxxviii, clxxix} For example, a healthy and productive workforce is critical for fostering an economically competitive society and health security.^{clxxx} It is estimated that approximately one-third of economic growth in developed countries can be attributed to investments in health.^{clxxxi} Investing in health is therefore a strategic imperative that requires coordinated and sustained investments across sectors.

4. Policy considerations

Based on the critical success factors assessed, the following concise policy considerations can support national-level governments in LMICs and HICs to improve the process for determining health financing and close the financing gap for NCDs. Each of these recommendations is informed by our review of the literature, case study analysis, and interviews but may need to be adapted for local contexts. Given this, opportunities for regional and global stakeholders to support the implementation of these policy actions through broader geographic outreach are also highlighted.

Consideration 1: Establish, review, or update long-term national plans with clear targets to address the growing NCD burden

Because a broader set of stakeholders and innovative financing mechanisms are involved in funding NCDs, there is a risk of increased fragmentation and inefficiencies. To address this, national plans with clear milestones for health and NCDs should be established that link tactics and goals across high-impact areas identified by local investment cases. A comprehensive plan is also important and should include consideration of the investment level and the need to ensure that financing is continually allocated to areas of high-value care. To optimize ROI, NCD targets should also illustrate where a link to broader fiscal goals is possible (e.g., infectious disease control, economic goals) and issues of political economy associated with health financing.

As highlighted by the WHO Global Action Plan 2013–2030, countries should develop and implement multisectoral national plans working in tandem with ministries of finance to prioritize budget allocation for NCDs.^{clxxxii} By 2030, WHO aims for at least 80% of countries to have developed an NCD national strategy.^{clxxxiii} For the development and implementation of national NCD plans, governments should explore the following:

- Tactics and goals that the NCD action plan should consider for inclusion
- The opportunity for NGOs and the private sector within the overarching strategy to bridge the financing gap
- The role and types of incentives that could be implemented to attract private sector financing
- How NCD action plans can be implemented to align with broader economic frameworks
- The availability of sustainable long-term financing

Consideration 2: Establish mechanisms to collect disaggregated data on spending and outcomes to inform preferred NCD interventions

Data collection in the local or regional context is needed to inform health financing investment cases and characterize ROI for policymakers, which has been found to be particularly important in LMICs. In HICs, local data on NCD spending and outcomes can help identify areas of high-value care where more resources should be allocated—and similarly where resources are being wasted or used for low-value care. Investing in infrastructure to improve local data collection can support the development of metrics and KPIs used to track progress toward national, regional, and global goals. In HICs, there is often granular data on outcomes of investing in health, but this is not necessarily reconciled with ROI estimates. This supports transparency and budget accountability and ensures that expected returns are realized over time.

Evidence-based decision-making that incorporates both financing and outcome-driven analyses is important, allowing fit-for-purpose monitoring and further adjustments of programs, as needed.

Consideration 3: Develop local investment cases that highlight the return on investment from investing in NCD prevention and care

Investment cases can support policymakers to ensure that health financing mechanisms focus on high-value care for NCDs by identifying where health outcomes can be improved most effectively, with the highest ROI. A global perspective could set out best practices for investment cases, such as the following:

- Using local (where available) or regional data
- Evaluating trade-offs (i.e., between different programs or interventions) in allocating a limited funding budget and including considerations of allocative efficiency for health financing to optimize investments in high-value care and assess the impact of raising additional revenue
- Defining key metrics and outcomes that matter to a wide range of stakeholders, including finance, labor, and health ministers, which should be included within investment cases
- Introducing comparative investment benchmarks
- Highlighting co-benefits

This should include the ROI associated with the health of patients with NCDs, as well as evidence of broader returns to health financing decisions, to identify both complementary health outcomes (e.g., returns to other areas of health beyond NCDs) and broader social and economic returns, such as productivity impacts on the economy. ROI assessments that reflect local ecosystem dynamics are important as they allow for national implementation based on available resources and national strategies.

Consideration 4: Establish formal mechanisms to facilitate multistakeholder dialogue on health and fiscal policy priorities

There is a greater opportunity to connect priorities across government ministries and ensure that the actions within each ministry are both consistent and mutually supportive to achieve a set of overarching goals. Formal mechanisms should facilitate greater dialogue, particularly between budget holders (finance ministers) and budget executors (health ministers). However, other relevant nongovernmental stakeholders that play a critical role in health financing, particularly in LMICs, should also be included in these dialogues and can play a role in supporting cross-ministerial collaboration. There is some evidence that these dialogues are recognized as important. However, they should represent meaningful communication leading to policy action rather than a superficial “tick-box” exercise with no tangible outcomes. This builds on previous initiatives:

- In 2011, the OECD established the Joint Network of Senior Budget and Health Officials to facilitate greater dialogue between ministers of health and finance.^{clxxxiv}
- In 2019, the Japanese government responded to the G20 call for health and finance ministers to collaborate on achieving UHC by hosting a joint meeting of finance and health ministers intended to establish greater commitments to such collaboration.^{clxxxv} Ministers across the G20 reaffirmed their commitment to UHC, leading to improved dialogue between health and finance ministers.^{clxxxvi} The G20 Joint Finance-Health Task Force was established to strengthen collaboration on pandemic prevention, preparedness, and response. It operates under the G20 umbrella, and its secretariat is housed within the WHO, with support from the World Bank.

A global perspective can set out best practices for establishing formal mechanisms. This could include the following:

- Health care as a standard item for each G7/G20 presidency agenda
- Processes for greater transparency around the outcomes from interministerial dialogues and how these have led to policymaking decisions, to foster accountability
- Articulating the role of nongovernmental stakeholders—for example, the private sector and civil society—in these dialogues and the benefits and opportunities for including these groups

This could include formal coordination mechanisms such as joint MoH–MoF budget committees for NCDs, medium-term expenditure frameworks with NCD lines, and health impact assessments in fiscal policy.

Consideration 5: Include health, particularly the prevention and management of NCDs, in related nonhealth policy planning and budgeting

The role of addressing NCDs in other policy priorities must be recognized. This includes the current focus on defense and strengthening population resilience. It also includes recognizing the benefits of investing in NCDs for health system resilience in the event of a health crisis. Economic frameworks and budgets should be aligned with health priorities, as set out in national plans (recommendation 4) and supported through interministerial dialogue (recommendation 1). A global assessment could highlight best practices that establish health as a key driver for economic prosperity and national security to support greater flexibility in health budgets (turning competition into complementarity) and could consider the following:

- Climate impacts on NCDs: For example, financing decisions should consider the importance of synergistic interventions that establish climate-resilient health systems, including the impact of climate change on NCD mortality, morbidity, and exposure to risk factors.^{clxxxvii}
- The importance of healthy populations for national security: For example, 1.5% of NATO defense commitment aimed at ensuring civil preparedness and resilience could be broadened to include health investments.^{clxxxviii}

Appendix: Research approach

The research approach followed three key steps: a literature review, a case study analysis of innovative financing mechanisms for NCDs, and stakeholder interviews.

Literature review

This first step consisted of a global review of qualitative and quantitative evidence, with a focus on evidence published within the past three years, to understand the current situation in health financing for NCDs globally, assess the evidence on returns to investing in NCDs, and select innovative financing mechanisms for in-depth analysis. The literature review included academic and governmental policy reports, NGO publications, and gray literature. Searches were conducted using Google and Google Scholar with key terms such as “non-communicable diseases,” “health financing,” and “return on investment,”^{clxxxix} resulting in 120 publications reviewed.

Case study analysis of innovative financing mechanisms

Following the literature review, we closely examined examples where countries had implemented approaches to increase spending levels dedicated to NCDs. Specifically, we chose a set of innovative financing mechanisms. An initial review resulted in 22 possible mechanisms for analysis, primarily from LMICs, covering examples from Africa, Asia, and Latin America.^{cx} These included mechanisms and programs specifically implemented within the scope of addressing NCDs, including novel health insurance models, debt swap schemes, DIBs, and health taxes. Case studies were then selected based on four key criteria:

- (1) The implementation of the financing mechanism supported government or public sector involvement for public health provision
- (2) The mechanism was implemented with evidence of a positive impact on fiscal spending priorities
- (3) The mechanism was specific to at least one NCD
- (4) The mechanism was introduced recently or underwent meaningful revisions within the past 10 years

This resulted in six examples for further investigation (**Table**). It is often the case that examples from HICs were often used to draw lessons for LMICs; however, a purposeful decision was made to focus on case studies from LMICs and consider the lessons for HICs.

Table A1: Summary of case studies

Financing mechanism	Case study	Geography	Year of implementation	Year of most recent revisions
Health tax	Tax reform and dedicated investment (tobacco and alcohol)	Philippines	2012	2019—reform following UNDP investment case
	Tax reform and dedicated investment (tobacco and alcohol)	Costa Rica	2012	2021—reform proposed but not implemented

Health insurance scheme	Community-based health insurance schemes	Rwanda	1999—introduced in three districts	2020—coverage expanded
	Social health insurance reform	Kenya	2023—Social Health Insurance Act approved	Ongoing implementation
Debt swap	Addressing public debate (D2H)	Cameroon–Spain; Indonesia–Australia; Indonesia–Germany	2007—first debt swap between Indonesia and Germany	2024—additional debt swaps between Germany–Indonesia
New financial tools	Maternal health DIB	India	2017	N/A
(Development investment bonds)	Cataract surgery DIB	Cameroon	2018	N/A

Stakeholder interviews

Interviews (n = 10) were conducted with stakeholders across academia, NGOs, and representatives from pharmaceutical trade associations (**Table**). The purpose of these interviews was to validate our characterization of the health financing problem, understand the role of ROI in health financing decisions, and supplement our understanding of the lessons from case studies of relevant innovative financing mechanisms. Most of the stakeholders interviewed had knowledge of at least one of the case study mechanisms in LMICs as well as expertise on healthcare financing for NCDs. Stakeholders from Australia and Germany were also included to provide additional context on financing policies in HIC settings and to consider the role of these countries in D2H swaps.

Table A2: Summary of stakeholders interviewed

Stakeholder group	Stakeholder organization	Expert interviewee
Academia and NGOs	Results for Development; Financing Accelerator Network (FAN) for NCDs	Adeel Ishtiaq, previously Program Director, Global Health; Management Team; Network Manager
	Access Accelerated	Herb Riband, Executive Director
	WHO	Dr. Alexey Kulikov, Head of Partnerships and Operations, Secretariat of the UN Interagency Task Force on Noncommunicable Diseases
	African Institute for Development Policy	Dr. Jackson Otieno, Senior Research and Policy Analyst—Director
	World Medical Association; PharmaAccess (Kenya)	Dr. Jacqueline W. Kitulu, President-Elect; Director

	University of Hyderabad	Prof. Alok Kumar Mishra, Professor in the School of Economics
Pharmaceutical industry	International Pharmaceutical Manufacturers Group (Indonesia)	Ani Rahardjo, Executive Director
	Medicines Australia	Elizabeth De Somer, CEO
	Association of Research-Based Pharmaceutical Companies (vfa) (Germany)	Harald Zimmer, Head of International Affairs
	The Indian Pharmaceutical Alliance (IPA)	Parikshit Chaudhari, Representative from Market Access and Medical Affairs Division

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ANNEX 1

Innovative financing schemes

- **Health taxes:** Imposed on the consumption of goods that are harmful to health, often used to discourage unhealthy behavior and finance public health systems; revenues can be earmarked specifically for health spending
- **Debt swaps:** Agreements through which a portion of a country’s external debt is forgiven in exchange for commitments to invest the equivalent amount into domestic health programs
- **Development impact bonds:** A results-based financing mechanism whereby private investors fund development programs and receive repayment (typically from government or donors) by achieving agreed health outcomes
- **Insurance schemes:** Not-for-profit (e.g., CBHI) or government-regulated (e.g., social health insurance) insurance models to extend health financing and coverage to populations with limited access to and coverage for health care

ANNEX 2

Barriers to NCD financing addressed by each case study

Barriers addressed by case studies	Health Tax 1	Health Tax 2	CBHI	SHIR	Debt2Health	DIB 1	DIB 2
1: Fragmentation in decision-making on a governmental level (i.e., between MoH & MoF regarding budget allocation based on ROI evidence)	✓		✓				
2: Short-term spending and outcomes are prioritized, whereas advancing a health system often needs longer-term investment			✓		✓		
3: Overall lack of public fiscal space and a political challenge to increase it by raising taxes, reallocating resources, or directing foreign aid	✓	✓			✓	✓	✓
4: Other policy areas are gaining budget share at the expense of investing in health (e.g., resilience and security)	✓	✓	✓	✓	✓	✓	✓

Health Tax 1 = Philippines health tax; Health Tax 2 = Costa Rica health tax; CBHI = community-based health insurance (Rwanda); SHIR = Social Health Insurance Reform (Kenya); DIB 1 = Cameroon Development Impact Bond; DIB 2 = India DIB.

ANNEX 3

Key finding 1: The design and governance of financing mechanisms are critical to ensure success

	1.1 Dialogue between key stakeholders, particularly the Minister of Health and Minister of Finance, ensured sufficient funding commitments for healthcare
	1.2 Embedding the ROI from health and population goals within economic development frameworks
	1.3 Policy should be embedded in a coherent, evidence-backed strategy aligned with political commitments and goals
	1.4. Partnership approaches that facilitate multistakeholder efforts can mobilize additional resources for health financing and support budget credibility

1.1: Costa Rica, the Philippines, Kenya, and Rwanda; 1.2: Rwanda; 1.3: Kenya; 1.4: India.

Key finding 2: Investments are linked to clear priorities within the health system

	2.1 Transparency in addressing specific health-related goals that have broad public support with ongoing efforts to monitor progress and impact
	2.2 Well-defined metrics and key performance indicators (KPIs), which can monitor progress and impact while also informing any necessary adaptations
	2.3 Allocating funds to high-value, evidence-based health interventions can reduce unnecessary health expenditures and reduce inefficient spending on low-value healthcare provision

2.1: Costa Rica and Philippines; 2.2: Australia, Cameroon, India, and Rwanda; 2.3: Australia, Cameroon, Germany, and Indonesia (Debt2Health), plus Cameroon and the Philippines.

Key finding 3: Investing in NCDs contributes to economic growth and national security

	3.1 Broader health system resilience, particularly in low- and middle-income countries but also in HICs, can support investments in health overall
	3.2 Evidence on how health contributes to economic goals, improving economic productivity, contributing to growth, and addressing the rising cost of living
	3.3 The role of healthcare in terms of political priorities – link to defense and link to climate transition

3.1: Rwanda; 3.2: India and Rwanda; 3.3: United States.

ANNEX 4

Policy considerations

A series of concise policy considerations can support national-level governments to close the financing gap for NCDs. While we focus on a global perspective, each policy must be adapted for local contexts.

Consideration 1: Establish formal mechanisms to facilitate multistakeholder dialogue on health and fiscal policy priorities

There is a need to coordinate policy priorities across government ministries and ensure that the actions within each ministry are both consistent and mutually supportive to achieve a set of overarching goals. Formal mechanisms should facilitate greater dialogue and align decision makers from different ministries (with fragmented responsibilities). There is some evidence that these dialogues are recognized as important; however, they must represent meaningful communication rather than a tick-box exercise. A global overview can set out best practices for establishing formal, tailored mechanisms. This could include processes for greater transparency around policymaking outcomes from interministerial dialogues and articulating the role, benefits, and limitations of including nongovernmental stakeholders in these dialogues.

Consideration 2: Collect disaggregated data on spending and outcomes for NCD interventions

Local and regional data is needed to develop health financing investment cases that demonstrate ROI for policymakers, particularly in LMICs. Investing in infrastructure to improve local data collection (i.e., national accounts) can support this while also tracking progress to ensure transparency, budget execution, and accountability. While HICs often collect granular data on health outcomes, this is typically not reconciled with estimates of ROI. Furthermore, appropriate data collection supports transparency and budget accountability while ensuring that expected returns are achieved over time and the design framework allows for any recalibration, as needed.

Consideration 3: Develop local investment cases to articulate the ROI of health financing for high-value prevention and care for NCDs and to optimize investment decisions

Co-created investment cases by relevant stakeholders in governments can support policymakers to ensure that health financing mechanisms are focused on prevention and high-value care for NCDs by identifying where health outcomes can be improved most effectively and efficiently, with the highest return on investment. A global perspective could support this by setting out best practices such as using local data (where available) or regional data, considering allocative efficiency for health financing to optimize investments, and defining key metrics and outcomes that matter to a wide range of stakeholders. These investment cases should include both the direct health benefits for people living with NCDs and the broader economic and social returns of well-targeted health financing.

Consideration 4: Establish, review, or update long-term national plans with clear targets to address the growing NCD burden

As a broader set of stakeholders and innovative financing mechanisms become involved in funding for NCDs, there is a risk of increased fragmentation and inefficiencies. To address this, national plans for health and NCDs should be established that link tactics and goals across high-impact areas identified by local investment cases. As highlighted by the WHO Global Action Plan for the Prevention and Control of NCDs 2013–2030, countries should develop and implement multisectoral national plans working in tandem with the MoF to prioritize budgets for NCDs.^{clxxxviii} Holistic guidance could establish general principles for

national plans, including tactics and goals, opportunities for NGO and private sector involvement, incentives for private sector financing, and alignment of NCD plans with broader economic frameworks.

Consideration 5: Include health, particularly the prevention and management of NCDs, in nonhealth policy planning and budgeting

Health is a cross-sectoral issue that can contribute to multiple domains, such as trade, technology, and security. In that context, the role of addressing NCDs in other policy priorities must be recognized. There are best practices where the budget for health has been considered when addressing other key political priorities. For example, the current focus on defense and ensuring the population can support different forms of resilience should incorporate the role of investing in health and NCDs. For another example, 1.5% of NATO defense commitment to ensure civil preparedness and resilience could be broadened to include health investments.^{clxxxviii} Financing decisions should consider the importance of synergistic interventions, such as education systems that address health care workforce shortages and promote healthy lifestyles; urban planning initiatives; and climate-resilient health systems that account for the impact of climate change on NCD mortality, morbidity, and exposure to risk factors.^{clxxxviii}

^{clxxxix} Other key search terms include, but are not limited to, the following: “funding,” “financing challenges,” “health budget,” “health demand,” “financial strain,” “disease burden,” “high-value care,” “investing in health,” “cardiovascular disease,” “stroke,” “hypertension,” “political priorities,” “implementation,” “multistakeholder,” “health minister,” “finance minister,” and “demand for health services.”

^{cx} We also considered case studies from HICs, such as Australia, Germany, and Singapore, but these mechanisms did not meet additional criteria. Evidence from the literature review and interviews considering HICs was considered instead.

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