SECURE WEBINAR 21

# Innovative Financing for Noncommunicable Diseases in Asia and The Pacific

PATH

# About PATH

## A global nonprofit improving public health

**70+ countries**
where PATH is improving health

**7 million lives saved**
through PATH-pioneered malaria control

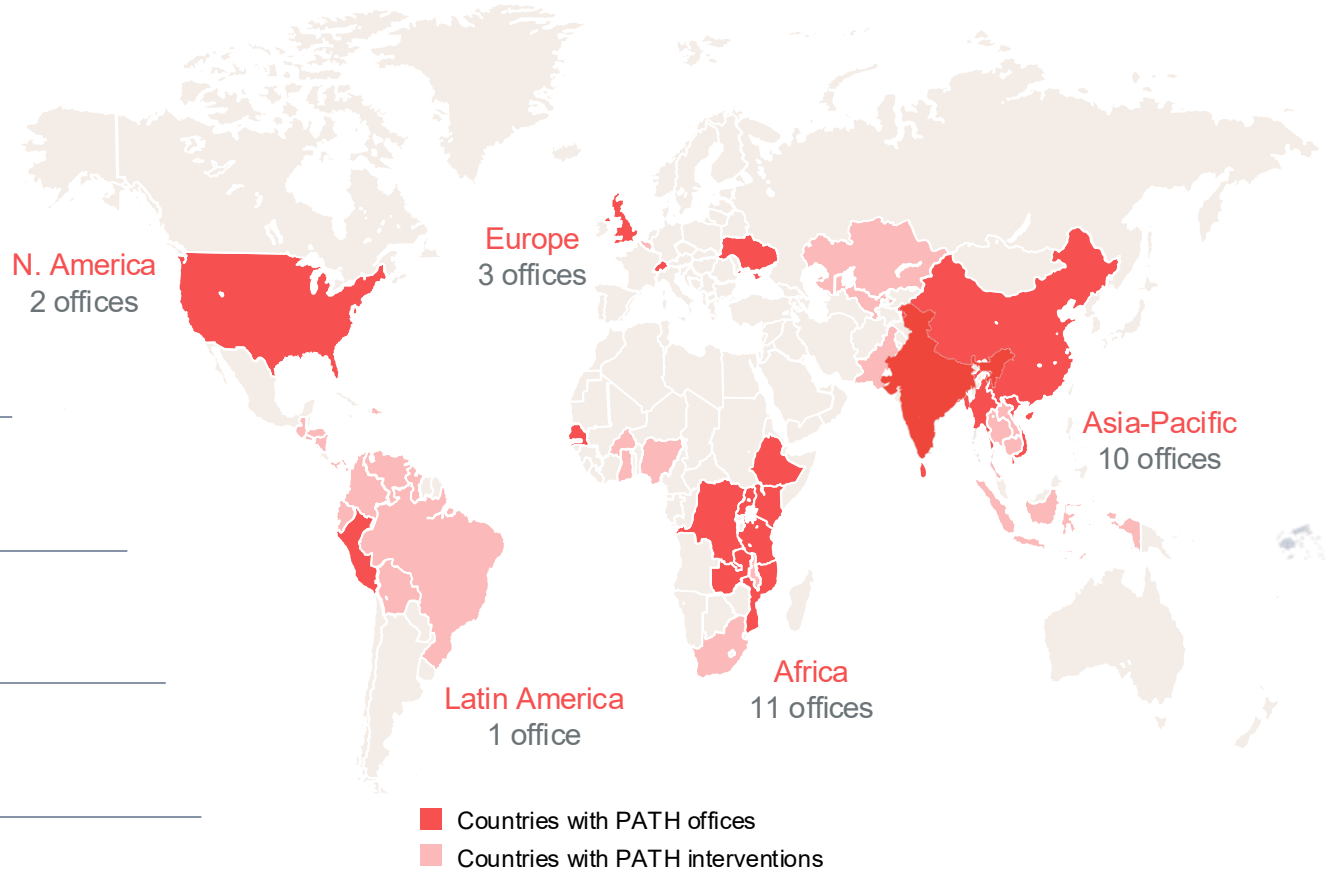
**900 million people**
reached with fortified rice

**7 billion**
vaccine vial monitors

**3200 professionals**
globally

**World's first freeze-preventive cold box**
Received WHO PQ (field trials in Nepal)

27 offices in 24 countries



# Overview of NCDs and Financing Challenges in Asia Pacific

# Burden of NCDs in Asia Pacific

NCDs are responsible for 7 of the top 10 leading causes of mortality and account for 28 premature deaths every minute globally

**43M**

Deaths attributed to NCDs in 2021. Of these **18M** occurred in the ages of 30-70 [1]

**$47 trillion**

the global cost of lost productivity from the four major NCDs** plus mental health conditions, between 2011 and 2030 [2]

** Cardiovascular diseases, cancer, diabetes, chronic respiratory diseases

**62%**

of deaths in Southeast Asia

**87%**

in the Western Pacific

**23%**

Chances of premature mortality in Southeast Asia

**16%**

in the Western Pacific

**Disparities in NCD response in Asia Pacific may be attributed to**

**Country economies**
**– HICs vs LMICs/LICs**

**Demographic transitions**
**– No, of people >60 years expected to rise to 1.3B by 2050**

**Socioeconomic transitions**
**– E.g., urbanization, changing dietary patterns, lifestyle**

[1] *WHO, 2024. Noncommunicable Diseases*

[2] *WHO. 2022. Invisible Numbers: The True Extent of Noncommunicable Diseases and What to Do about Them. Geneva.*

PATH

- Target 3.4 of the Sustainable Development Goal (SDG) 3 aims to reduce NCD-related premature mortality by 1/3rd between 2015 and 2030.

- UNCTAD (2019) identified an annual financing deficit of ~USD 371B to achieve SDG3.
- Shortfall in achieving SDG3.4 is alarming and worsened post COVID-19 pandemic.

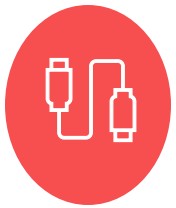
## Challenges in NCD Care

**Significant Differences in Clinical and Care Pathways**

**Huge Out-of-Pocket Expenditure**

**Economic Costs to Countries**

**Insufficient Quality of Care**



**Limited Access to Digital Health Technologies**

## Challenges in NCD Financing

**Budget Limitations and Competing Priorities**

**Health Workforce Constraints**

**High Treatment Costs**

**Limited Access to Preventive Programs**

**High Out-of-Pocket Expenditure**

**Low Private Sector Engagement**

**Fragmented Health Systems**

**Governance and Accountability Gaps**

NCDs have historically received disproportionately low funding compared to their overwhelming disease burden worldwide.

**1-2%**

NCD financing out of total health funding globally. Remained stagnant until 2015

**2%**

of development assistance for health (DAH) was allocated to NCDs in 2018, which plummeted to 1% in 2020

Effective health financing can significantly strengthen the health systems of LMICs for tackling NCDs by:

- Addressing funding gaps,
- Improving access to care,
- Enhancing the quality of services, and
- Reducing the financial burden on individuals
- Ensuring that limited public resources are used efficiently and equitably.

## Three Major Financing Models for NCDs

**Government-led Models**:

- Increased access to healthcare services
- Improved financial protection for households
- Strengthening health infrastructure

**Private Sector Models:**

- Mobilising private investments and expertise
- Reducing health inequities

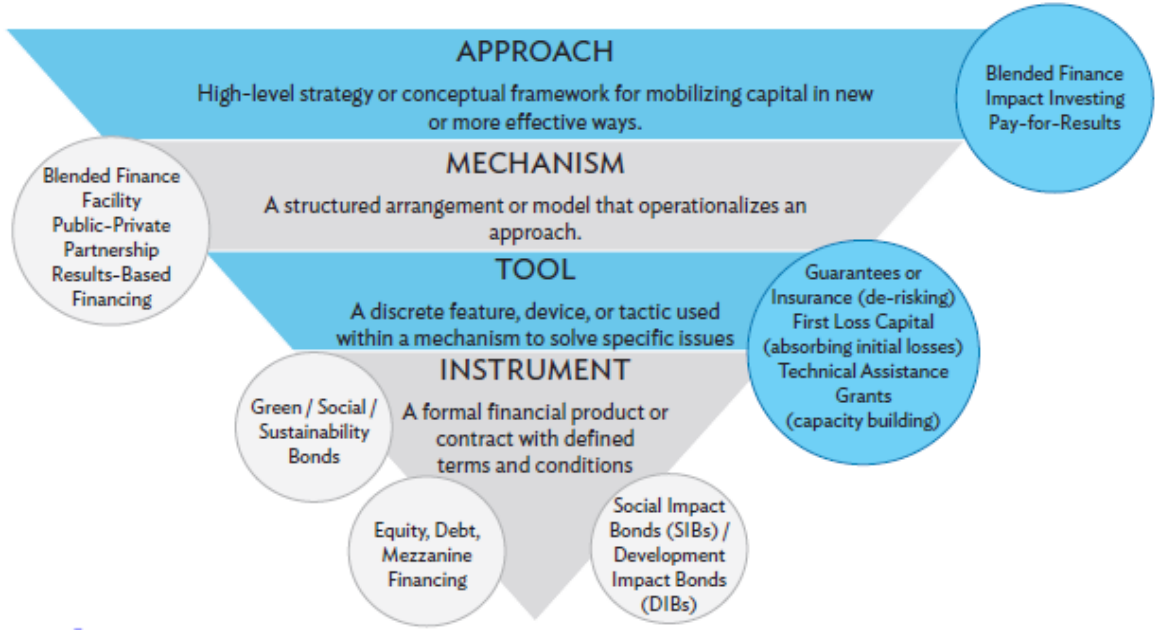
**Innovative Mechanisms**: Novel approaches and Performance-based Incentives to encourage efficiency and accountability

- Promotion of preventive health measures
- Strengthening governance and accountability

PATH

# Innovative Financing and its Application in Health

# Approach for the Study




**Big Picture of Innovative Financing:** Four Layered Framework

| Innovation in Financing | Health Financing Functions | NCD Care Continuum |
|---|---|---|
| **Source of Additional Funds Only** (No specific conditionality imposed on usage of funds, no catalytic effect and no measurement of impact) | Resource Generation | All stages: This does not inherently focus on any specific stage. |
| **Better Use of Existing Resources**<br>(Existing resources can be channelled and allocate to achieve leverage, additionality, catalytic effect, and impact creation in various ways – no concessionality) | Pooling, Purchasing | Health Promotion, Primary Prevention; May extend to Secondary Prevention if cost-effective screening or early detection is prioritised. |
| **Sources of Additional Funds and Better Use of Resources**<br>(New funds are used as concessional funds that cause additionality, leverage, catalytic effect, and impact) | Resource Generation, Pooling, Purchasing | Entire continuum: Emphasises integrated approaches across all stages. |

**Articulated Modalities of Innovative Financing for Health**

# Prominent Innovative Financing Mechanisms

## Impact Investing

**Creating a significant social impact while also offering a potential financial return**

Pursues social and/or environmental interests alongside financial goals

Bridges the gap between conventional philanthropy and government support by introducing profit-driven investments to generate social and environmental value.

## Results-Based Financing

**Performance-based Financing (PBF) or Pay for Performance (P4P)**

Payment is based on results to incentivize it

Transferring part of the risk from the donor to the implementing partner

Making room for flexibility and innovation on how to achieve sustainable results

## Public Private Partnerships

**Collaborative arrangements - public entities partner with private-sector actors** to design, finance, construct, and/or manage public projects or services.

Risks and rewards shared between parties: private sector assumes financial, technical, and operational risk in return for potential revenue; public sector does oversight to ensure public interest

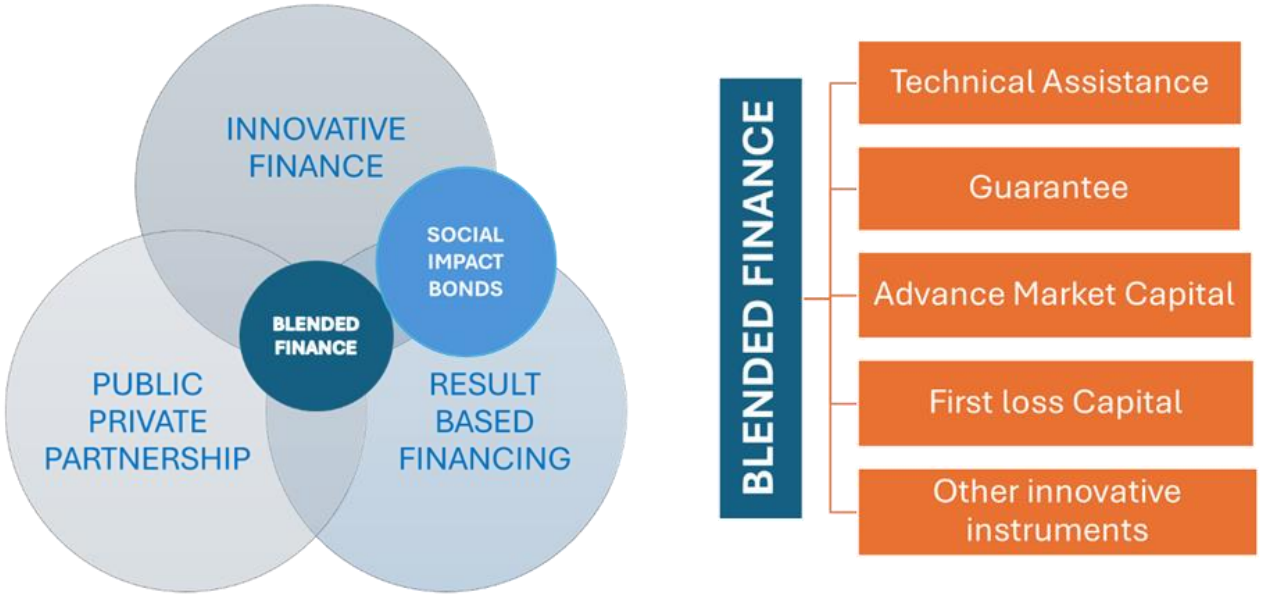
## Blended Finance

Brings “development funds” and “private investment” together

Applicable Concepts: **Concessionality, Additionality, Leveraging, Sustainability** and **Impact.**

Typically, deployment of Development Funds (TA Grants, Risk underwriting and Market incentives) precedes that of private investment.

Relationships among Innovative Financing Models




Adopted from: Andrea Felgi 2020; HEALTH FINANCE INSTITUTE

# Innovative Financing: Experience from Global Health

For global health, innovative financing emerged in the wake of raising the necessary resources for accomplishing health-related Millennium Development Goals (MDGs).

**Early initiatives** : GAVI – with support from IFFIm – PPP & AMC – ensure access to safe and effective vaccines for millions of children in need and GF-ATM – with support from (PRODUCT) RED and Debt2Health Initiative – scaled its efforts to fight AIDS, TB and Malaria.

However, The high-level **Taskforce on Innovative International Financing for Health Systems (2008) defines IF** as “non-traditional applications of ODA, joint public–private mechanisms, and flows that either support fundraising by tapping new resources or deliver financial solutions to development problems on the ground.” Thus, different from institutions that design and implement funds.

# Analysis from Health Sector

A total of 81 initiatives, 79 from health sector

Classified as International (47), National (28), and Sub-national (6)

52/81 – Clearly mention at least one of the health categories (NCDs, CDs, MCH)

50/52 – Either have a component of NCD coverage / have some implications for NCDs

The innovative funding models have been categorized into three distinct types according to health financing modalities:

Type 1 – relate only to additional funding sources (source innovation),

Type 2 – purely apply to the process of deploying or spending the existing funds (process innovations),

Type 3 – hybrid of the earlier two types that uses additional funds in innovative ways.

# Type 1 – Innovations that relate only to additional funding sources (Source Innovation)

- **Non-traditional revenue models** include crowdfunding, voluntary donations, and private-sector sales contributions, though sustainability and targeting toward preventive care remain challenges.

- **Sin taxes** and **Public Health Taxes** are common Type 1 innovations unless earmarked for health; and unlike Philippines' Sin Tax Reform Act and Thailand's Health Promotion Trust which constitute Type 3 innovations.

- **Government-led tax-based financing** - generally more predictable and sustainable revenue stream than private contributions but requires strong political committment and appropriately set tax rates to impact consumption.

- **Traditional forms of ODA without performance-related conditions** also categorized as Type 1 innovations - becoming rare as donors are increasingly typing funding to impact / performance.

# Type 2 – Innovations in the Usage of Funds (Process Innovations)

**Type 2 process innovations** involve reallocating existing domestic funds to prioritize health promotion, NCD interventions (e.g., prevention, screening, early detection). **E.g.,** Global Fund's integration of diabetes care into HIV/TB programs in remote regions, WHO's "Best Buys" for NCD prevention and control, and India's Ayushman Bharat initiative

- Multisectoral approach – Non-health sector such as pollution control, healthy city initiatives, and conditional cash transfer programs (e.g., Pantawid Pamilyang Pilipino Program in the Philippines) – demonstrate how existing funds can be repurposed to address NCD risks more effectively.

- In India - Pradhan Mantri Jan Aarogya Yojana (PMJAY) under the Ayushman Bharat initiative ensures provision of financial protection for accessing care at the higher levels of health facilities under both the public and private sectors. PM-JAY represents process innovation where existing (or committed incremental) public funds are spent through a demand-side financing mechanism to pay for in-hospital secondary and tertiary care.

Purchasing reform – adopted by some LMICs in the form of capitation or pay-for-performance models - can improve incentives for quality and efficiency but require robust institutional capacities.

**Type 2 Innovations underscore a shift toward cost-effective interventions that target the early stages of NCD development and promote intersectoral collaborations.**

# Type 3 – Innovations in Pooling and Deployment (Integrated and Hybrid Innovation)

**Type 3 innovations** integrate multiple financing functions - resource generation, pooling, and strategic purchasing to form comprehensive, sustainable financing models. **E.g.,** community-based insurance schemes (Vimo SEWA, PhilHealth, RSBY) and blended finance instruments (Health for All Bond)

- Private-sector contributions and several blended-financing schemes are increasingly employed to strengthen markets for innovative NCD solutions (e.g., through targeted support for social enterprises or novel technologies).

- PPP – another significant facet of Type 3 Innovation – through expansion of insurance coverage for NCDs, facilitating cutting-edge NCD research, or supporting major infrastructural investments such as hospitals or diagnostic centers

- Other examples of Type 3 Innovations: CSR, Earmarked Taxes for NCDs, Impact Bonds (high-risk, high-need areas), Digital loans, Alternative financial instruments

- Examples of integrating Investment Platforms and Health Innovation: SDG500, pooling resources to subsidize treatment cost, financial products to enable patient care through zero-interest loans and instalment-based payment for high-cost medication

**Type 3 innovations that combine resource mobilization with strategic pooling and deployment show the greatest potential by creating a dynamic financing ecosystem that not only secures sustainable funding for NCD prevention and care, but also aligns spending with broader health system goals, ultimately supporting more equitable and effective health outcomes.**

# Proposed Recommendations

# INNOVATIVE FINANCING FOR NONCOMMUNICABLE DISEASES IN ASIA AND THE PACIFIC

*Swati Mahajan, Priyanka Bajaj, Divya Wahi Malik, Rachana Parikh, Jae Kyoun Kim, Eduardo P. Banzon, and Vasoontara S. Yiengprugsawan*

ADB ASIAN DEVELOPMENT BANK

PATH

**For more information:** Dr. Priyanka Bajaj (pbajaj@path.org)