Donors, non-communicable diseases, and universal health coverage to high quality health care: an opportunity for action on global functions for health

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Summary:
The world is increasingly globalized, and has seen major economic and demographic changes. These factors have dramatically changed the global burden of disease, shifting from mostly rural pediatric infections in low income countries to mostly urban adult comorbidity from non-communicable diseases (NCDs) in middle income countries. As countries become less reliant on development assistance for health to support their individual needs, the globalization of disease will need a new type of global health engagement. Global functions- those functions that transcend national sovereignty and provide dispersible benefits to all- will take increasing importance as countries grapple with providing universal coverage to high quality care for NCDs.

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In years past, the face of the global burden of disease was a rural child suffering undernutrition and infections in a low-income country. The case for donor intervention—both bilateral and philanthropic—was morally, technically, and economically clear. Today, however, it is more commonly an urban adult suffering multiple chronic diseases in a middle-income country. How could donors provide universal health coverage (UHC) or meet such an expansive need for health care services? Would they invest in adults, who have already had a shot at life and whose lifestyle choices are supposedly to blame? What role could they have in a country with resources? These questions need answers.

In 2013, the *Lancet* Commission on Investing in Health (CIH) grouped the global health agenda into three categories: the unfinished agenda to reduce disparities in key infectious diseases and reproductive, maternal, and child health; the emerging agenda to curb non-communicable diseases (NCDs) and injuries; and the cost agenda to provide universal coverage to high quality health care (Figure 1).[1] Since that time, pandemic preparedness has yet again emerged as an additional priority. The donor response to these challenges primarily exists on two levels: global functions, which transcend national sovereignty to provide globally dispersible benefits, and country-specific functions, which are targeted interventions that improve the health of any individual country (Figure 1).[2, 3] Overwhelmingly, donors have focused their efforts on country-specific functions for the unfinished agenda, or as of late, on global functions for infectious diseases. Left unreconciled is the pressing need to address the global NCD crisis with strong health systems that equitably cover everyone.

Figure 1. *Global functions will remain important in global health, while country-specific functions will decrease as countries transition. Both will continue to support the major global health priorities. Adapted from Jamison et al, 1998.*[3]

That burden is enormous. NCDs accounted for 73% of global deaths (40 million people) in 2016, of which 75% (30 million) were in low- and middle-income countries (LMICs). A staggering 38% of global NCD deaths (15 million) occurred in working age adults in LMICs who are vital to their countries' economic growth.[4, 5] Yet, NCDs attract only 1.7% of development assistance for health.[6] Meanwhile, sector wide approaches and health system strengthening (which ostensibly provide NCD care) attract just 9.6% despite the burden of unsafe medical care: for example, in-hospital adverse events alone accounted for 23 million DALYs lost worldwide (15 million in LMIC).[6, 7] Furthermore, about half of the world's 7.3 billion people do not even have sufficient access to essential care, and health-related costs expose almost 1 billion people to financial hardship and impoverishment each year.[8] The world's poor suffer more from NCDs, are less able to access minimum quality care, and are more vulnerable to catastrophic health expenditure.

Understanding donor choices: challenges best solved by countries?
A confluence of factors helps to explain donor paralysis in responding to NCDs, health system strengthening, and UHC.

First, the additional cost to achieve Sustainable Development Goal 3 (SDG3) in LMIC is projected at US$274–$371 billion annually through 2030; the CIH estimated that about US$70 billion of that would be needed for the unfinished agenda alone.[1, 9] With only US$38 billion per year in total development assistance for health, it is overwhelming for donors to provide country-specific functions to these ends.[6]

Second, the emerging and cost agendas are complicated by the difficulty of measuring the usual donor metrics of lives saved or DALYs averted. Health systems, UHC, and NCDs are the products of many variables, many of which exist outside of health care system control; interventions in these domains generally do not produce measurable results in short timeframes.

Finally, NCDs have not enjoyed the moral backing that other diseases have. Long held to be the products of choice and chance, NCDs are still incorrectly thought of as privately held diseases of the elderly in rich countries that are incapable of spreading through and destabilizing societies.[10] Pitted against infectious diseases, which are often seen as acute, public, and global threats, NCDs have been overshadowed.

Other factors certainly contribute, like complex, multifactorial etiologies, a weak civil society demand for action, and vested commercial interests in maintaining the status quo. Taken together, all of these factors—too big, too complex, wrong turf—may seem to justify low donor engagement, but donor investment in global functions may be a rational and realistic way to meaningfully enhance donor assistance.

Global functions: a rational choice for donors

Global functions for health are a small but critical part of the response to today's global health challenges. Global functions globalize health 'goods' and contain health 'bads'; flagship examples include creation of a safer world from the "Big 3" infectious diseases (via PEPFAR and the Global Fund to Fight AIDS, Tuberculosis, and Malaria) or vaccine-preventable diseases (via Gavi, the Vaccine Alliance), or through international cooperative mitigation of the tobacco pandemic (via the Framework Convention on Tobacco Control).

Compared with country-specific functions, global functions can efficiently support countries to fulfill their health systems' obligations by globalizing the benefits of relatively small investments. Yet they are grossly underprovided,[2] probably because of some combination of free-riding, zero-sum policies, and vastly diverse country needs . There is an increasingly important opportunity for donors to provide global public goods for health in general, and specifically on the emerging and cost agendas.

UHC, health care service delivery, and action on NCDs are interdependent challenges that are ripe for global collective action and co-investment. Resilient, equitable, and efficient health systems by definition will provide high quality care for all patients, irrespective of acuity or disease category. Furthermore, health policy-makers are increasingly focused on both global collective action for health (though mostly for infectious diseases) and the tremendous costs of their local NCD burdens. This, in conjunction with the upcoming United Nations General

Assembly Third High-level Meeting on NCDs, provides the appropriate timing for meaningful global-scale action on both the emerging and cost agendas.

It is unclear what the most cost-effective or practical global functions are in this domain. Current and anticipated challenges should determine which goods donors provide. Among the many possibilities, we identify four:

First, despite the Paris Declaration on Aid Effectiveness,[11] donor financing remains uncoordinated and impractically country-specific. Coordinated donor investments in global issue championship and advocacy can lead to a virtuous cycle, whereby small investments can lead to strong issue attention, financial backing, and actor power.

Global functions must remain in service to country-owned health development priorities, and not the other way around. But sometimes sovereignty is counterproductive to health. When challenges exist at the interface of donors and countries—e.g. when states prioritize non-evidence based approaches, cozy up to problematic commercial interests (as Zimbabwe has with the tobacco industry), suffer from despotic rule, or inadequately prioritize vulnerable populations—global functions may help by creating global public goods, exerting pressure on both governors and the governed, and by leveraging negative externalities to incentivize participation in the international order.

Second, global NCD and health system research funding often better targets rich country needs, like incremental drug development, than LMIC needs, like new cost-effective therapies or improved implementation strategies.[12, 13] The donor community can enhance pro-poor research and development investments targeted at middle-income countries (e.g. through research supporting the implementation and scale-up of the WHO atherosclerotic heart disease program, Global Hearts, into existing primary care infrastructures).[14]

Third, efforts to reduce individual-level high-risk behaviors (e.g. substance use, poor diet, and physical inactivity) have not substantially reduced the NCD burden.[15] Donors can refocus NCD prevention efforts on more cost-effective population-level interventions aimed at mitigating the globalization of harmful substances (e.g. tobacco, alcohol, and sugar-sweetened foods) and promoting healthy physical environments, studied across LMIC settings. For example, the insufficient evidence supporting the use of WHO Best Buy interventions in LMIC is a potential funding opportunity for donors.[16]

Finally, although health promotion will be important for generations to come, high quality, high-value health care for all is needed now. Today there exists a vibrant though often problematic private sector that will continue to exist irrespective of policy-makers' ideologies and values. Coordinated investments to help countries steward mixed, public-private health systems (e.g. in the Joint Learning Network) will be critical to attaining threshold quality and value of health systems worldwide.[17]

Striking balance with the provision of global functions

Finite resources mandate allocative efficiency between global and country-specific functions, and among competing priorities. Zero-sum shifts in donor allocations can be politicized and

crippling, so synergistic, win-win strategies are paramount. For example, donors can continue to exploit natural synergies between HIV and NCD interventions from local to global scale so that both disease groups win and global functions enhance needed country functions.

Countries will not consume global public goods if they do not demand them or deem them useful, jeopardizing returns on investment. Donors, then, must be intensely focused on providing global functions that are responsive to country needs, useful in nearly any country context, and support their most vulnerable groups.

Global functions for the emerging and cost agendas should not replace other pressing global health challenges. The unfinished agenda remains unfinished, pandemics will continue to present themselves, and individual nation-states will remain the most important actors in improving the health of their populations. The staggering burden of NCDs, iatrogenic morbidity and mortality, and impoverishment from out of pocket payments are urgent global health challenges. Amid limited donor resources, transition to middle-income status, and accompanying demographic and health shifts, the landscape of donor engagement in health is changing. Global functions may emerge as the new part for donors to play in the future of global health.

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