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The impact of UN high-level meetings on non-communicable disease funding and policy implementation

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ABSTRACT

Since the original UN General Assembly 'special session' for HIV/AIDS, there has been a proliferation of health-related high-level meetings (HLMs), including three for non-communicable diseases (NCDs) and a 2019 HLM on universal health coverage that was closely aligned to the NCD framework. This paper attempts to assess the impact of these meetings in terms of funding allocations, domestic NCD policy implementation, as well as the level of international engagement with the HLMs by reviewing attendance data and records of statements ('interventions') made by country delegations. In contrast to HIV/AIDS, whilst NCDs have enjoyed a marked rise in international political exposure and high-level political commitments, these have not always translated into national policy implementation or greater funding allocations. This is true even for countries that have engaged most deeply with HLMs. These findings should give pause to NCD advocacy groups that expend substantial energy in calling for further high-level political commitments and highlight the need to focus support on the translation of commitments into sustainably funded action.

SUMMARY BOX

⇒ There has been a proliferation of health-related 'special sessions' and 'high-level meetings' (HLMs) held during or alongside United Nations General Assembly meetings, including several focused on non-communicable diseases.
⇒ Despite their high profile in the global health architecture, there is scant evidence that these meetings influence financing or domestic policy implementation without attendant work from countries, UN agencies and civil society.
⇒ While some HLMs—especially those related to HIV/AIDS—do seem to have catalysed action, it is important that health advocates maintain pressure at the domestic level. This is where grand oratory is translated into concrete spending and policy commitments that actually benefit patients and communities.

BACKGROUND

Over the past decade, non-communicable diseases (NCDs) have moved from an abstract concept to a development priority that is critical to the achievement of the Sustainable Development Goals (SDGs). Accounting for 74% of global deaths, the underlying socioeconomic, environmental and political factors contributing to growing NCD prevalence were articulated in three United Nations General Assembly (UNGA) high-level meetings (HLMs).[1] The need to address NCDs as a developmental challenge was further acknowledged with the adoption of an NCD-related SDG target 3.4.[2] The inclusion of NCDs in these global forums and recognition by heads of state of their significance has been viewed as one of the key requirements to securing a political framework that can justify, enable, and bind countries towards national prioritisation and implementation.

However, to what extent do political commitments translate into country-level investments, policies and programmes? The 2020 WHO Country Capacity Survey indicated that national NCD responses were particularly weak in ensuring policy coherence and delivering 'whole-of-society and whole-of-government' approaches.[3] For example, approximately 74% of countries reported having an operational multisectoral national health policy or plan, but only 46% confirmed they had an operational national multisectoral commission or mechanism to oversee the cross-sectoral coordination and collaboration on NCDs.[3] Recent research suggests that progress in implementing WHO-recommended NCD policies has stalled with half of all policies remaining unimplemented around the world over a decade after being endorsed by all 194 WHO member states.[4]

With the expiry of the NCD Global Monitoring Framework and the fourth HLM on NCDs in 2025, now is an apposite time to take stock of national-level progress. This paper seeks to examine the landscape of political

commitments articulated at the HLMs and to understand the degree of correlation of these commitments with overall budgetary allocations to NCDs and domestic NCD policy implementation.

UNGA HIGH-LEVEL MEETINGS

Over the last 20 years, several health issues have been prioritised on the global agenda through HLMs at the UNGA. In 2001, the first 'special session' was called by UN member states to address the social, economic and political determinants of HIV/AIDS. The outcome was a 'Declaration of Commitment',[5] which established a key framework for stakeholder engagement and set time-bound commitments and reporting mechanisms[6] that have been strengthened through subsequent UNGA HLMs on HIV/AIDS in 2006, 2011, 2016 and 2021. Following these meetings, substantial political and financial commitments were made, leading to the establishment of several global institutions and financing mechanisms, and the prioritisation of national resource allocation to align with the burden of disease.[7]

The apparent impact of the HIV/AIDS may explain the proliferation of these meetings for other health issues. Five other HLMs have been held during UN General Assembly sessions: on NCDs in 2011 (followed by meetings in 2014 and 2018)[8–10]; Ebola in 2014; antimicrobial resistance in 2016 (followed by meetings in 2019 and 2021)[11]; tuberculosis in 2018[12]; and universal health coverage (UHC) in 2019.[13 14] Three further HLMs are planned for 2023.

DECLARATIONS AND FRAMEWORKS

All of the high-level NCD meetings have led to negotiated political declarations and outcome documents; a comprehensive set of steps detailing how to achieve the vision articulated in the declaration. A fourth meeting held in Uruguay in the lead-up to the third UNGA HLM adopted a negotiated document—the *Montevideo Roadmap from 2018 to 2030*.[15] In 2019, a UNGA HLM on UHC[16] was held, with a Political Declaration closely aligned to the framework set out for NCDs (figure 1).

In the following sections, we examine the evidence for whether high-level international commitments have translated into action in two key areas; domestic policy implementation and financial commitments to NCDs. We also review the extent to which these HLMs have been prioritised by national delegations by reviewing attendance data and engagements in the form of interventions made ('intervention' is the UN term for a statement made by a delegate during a meeting, at the invitation of the presiding officer[17]).

PRIORITISATION OF THE NCD MEETINGS BY COUNTRY DELEGATIONS

With UNGA HLMs that span over a decade, the prioritisation of NCDs at the global level has shifted, as indicated by the timing and location of the meetings, as well as the participants. The first HLM was held during the 3rd–5th General Assembly Plenary Sessions in the General Plenary Hall,[18–23] while the 2014 HLM took place during the 101st to 104th Plenary sessions, perhaps indicating a lower priority.[24–28] The 2018 NCD HLM and the 2019 UHC HLM were held in parallel to the main plenary sessions.[29–31] The location of the meetings is significant as inclusion in the main plenary gives the topic more exposure and potentially more attendees.

As the NCD meetings were held in alternate meeting rooms in 2018 and 2019, we can infer that participants who prioritised attendance at the NCD session over the main session are likely to be particularly committed to

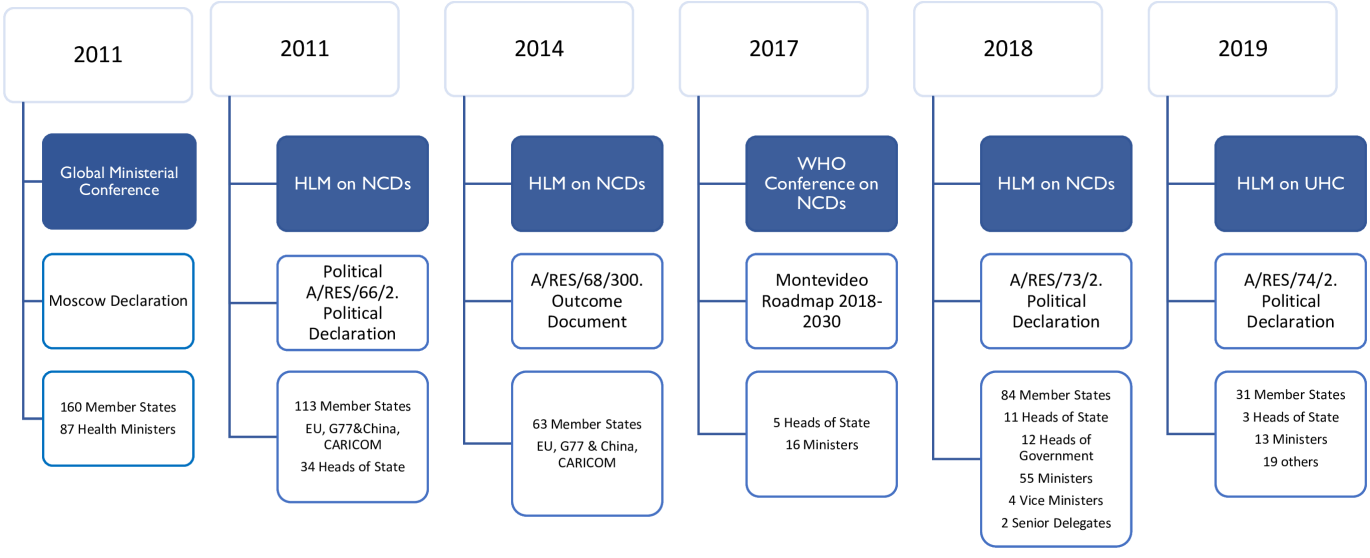

Figure 1 Negotiated documents for the NCD and UHC high-level meetings. HLM, high-level meeting; NCDs, non-communicable diseases; UHC, universal health coverage, EU, European Union; G77, Group of 77; CARICOM, Caribbean Community.

the cause. Attendance at the three UNGA HLMs varied, with 34 heads of state and a total of 113 member states in attendance in 2011,[32] 64 member states in 2014,[33] and 11 heads of state and 84 member states in 2018.[18 26 34–40] The UHC HLM saw a smaller attendance with 31 member states present.[41]

While attendance numbers can provide some insight, reviewing the engagement of member states through documented interventions during the HLMs can supply additional information about commitment and prioritisation. During the four HLMs, only six countries made interventions (Bangladesh, Brazil, Canada, Nigeria, the USA and Uruguay), as well as the European Union (EU) and Caribbean Community (CARICOM). Across all three NCD HLMs, there were interventions made by an additional eight countries; Barbados, Botswana, Chile, China, Jamaica, Kenya, Morocco and Trinidad and Tobago.[18 26 39 42–47] Among these, Uruguay and Trinidad and Tobago each hosted pivotal meetings to secure commitments on NCDs at the Port of Spain Summit held in 2007 and the Montevideo Conference in 2017, respectively.[48 49] Absent from this list is the Russian Federation, which made interventions at only two of the four UNGA HLMs, but hosted a ministerial meeting in Moscow in 2011 before the first UNGA HLM advocating for global and national prioritisation and investment which was cochaired at the Montevideo Conference in 2017.

DOMESTIC POLITICAL COMMITMENT

The commitments made in the 2011 Political Declaration prompted the development of coordinating mechanisms, including the establishment of the UN Interagency Taskforce, a Global Coordination Mechanism, a global monitoring framework with nine voluntary targets and 25 indicators and a Global Action Plan for 2013–2020 to support country implementation. In 2014, the outcome document from the second UNGA HLM prioritised commitments into four general policy areas: governance, risk factors, health systems and surveillance.[50]

To support countries in establishing or strengthening national NCD policies and plans, WHO member states have endorsed a series of 'menus' of NCD policy options that came to prominence in appendix 3 of the Global Action Plan.[51] Of these, 16 were considered cost-effective 'best buys'.[51] The latest iteration was endorsed in early 2023 and includes 30 best buys.[52] Reviewing WHO National Capacity Surveys[53] (an accountability mechanism that enables WHO and countries to assess policy implementation across a range of NCD focus areas) and the WHO Progress Monitors[54–56] (a scorecard that tracks coherence to a set of 10 progress monitoring indicators), it is possible to assess how countries are progressing in translating their global commitments at the national level.

A recent analysis indicated that a third of all WHO-backed policies had been implemented worldwide.[57] Approximately three-quarters (74%) of countries had integrated and implemented operational national strategy/action plans. Of these, 57% were multisectoral and in line with the WHO Global Action Plan on NCDs and WHO Best Buys[58]; an increase of 24% since 2015.[59] The existence of an operational unit, branch or department responsible for NCDs also grew, with 95% of countries reporting positively, up from 70% in 2017.[59] Policies on alcohol, tobacco and unhealthy foods had the lowest levels of implementation, and one-third of these policies had reversed.[57] Although data are collected on funding of specific activities and functions, information is not provided on how a plan is costed or how interventions are prioritised.[60] Member states that made interventions on NCDs during the four relevant HLMs have higher levels of policy implementation than other countries (table 1); however, mean policy implementation is actually falling for this group while rates are rising for others, although from a lower base.

FINANCIAL COMMITMENTS

Overall, total global health spending was US$8.8 trillion in 2019, up from US$7.4 trillion in 2015.[61] Development assistance for health (DAH) also increased, estimated at US$41 billion in 2019 up from US$8.1 billion in 1990.[61] Most of the rise took place primarily between 2001 and 2013: DAH remained relatively flat between 2013 and 2019,[61] with two-thirds of major donors reducing their DAH contributions between 2010 and 2015.[62] By 2020, these numbers had improved again but remained below globally recognised spending commitments.[63] NCD DAH contributions have grown over time in absolute levels,

Table 1 Implementation of WHO-recommended policies in 2020

	National integrated NCD action plan	National NCD targets and indicators	Routine collection of NCD mortality data	Guidelines for management of major NCDs
Countries that intervened at all four HLMs (n=6)	83%	100%	67%	67%
Countries that intervened at three HLMs (n=8)	87.5%	87.5%	25%	50%
All other countries	55.5%	54%	39%	48%

HLMs, high-level meetings; NCD, non-communicable disease.

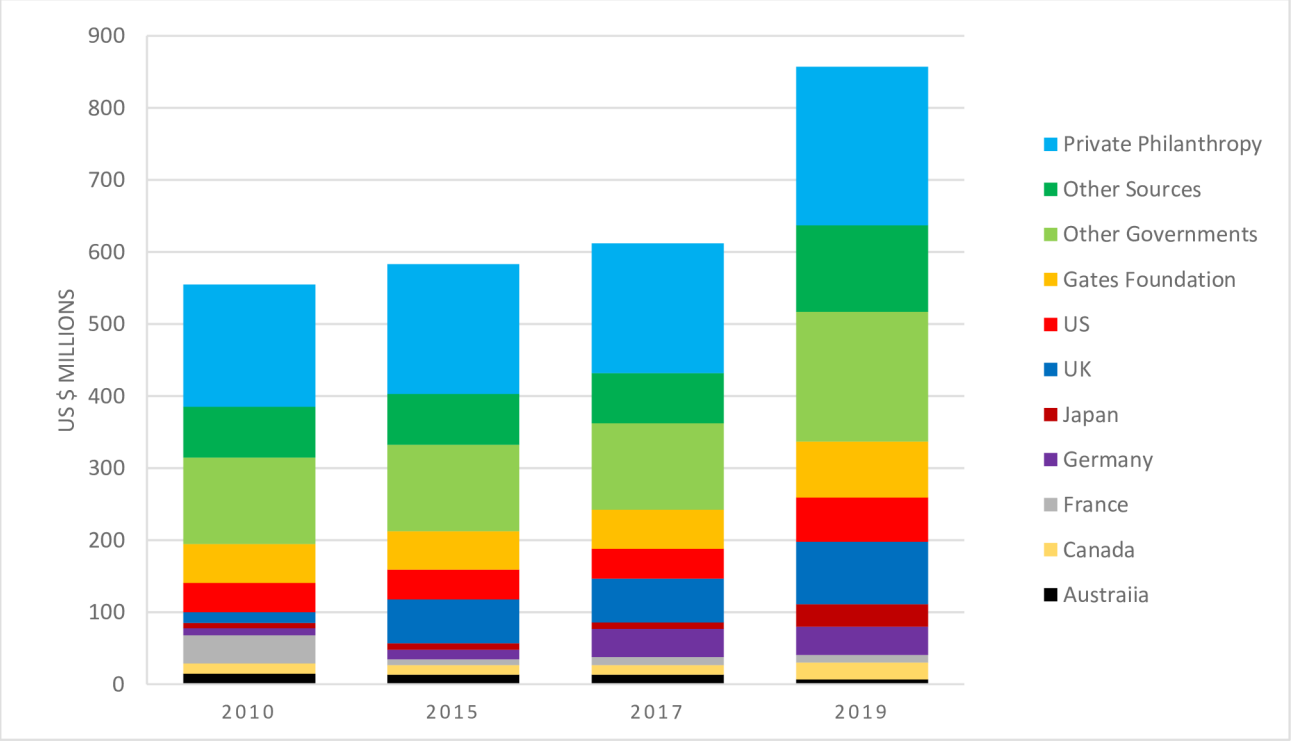

Figure 2 Non-communicable disease development assistance for health spending from 2010 to 2019.

but remain disproportionately underfunded in comparison with other disease areas.[64 65]

As figure 2 indicates, the primary donors and the channels through which DAH is dispersed are changing. The largest contributor to DAH for NCDs are private philanthropies, (41%); however, their share is falling over time.[66] The second highest contributors were bilaterals (41%), with the UK (8%) and the USA (8%) the largest investors, followed by Germany (4%), France (2%), Canada (2%) and Australia (2%).[66] The Gates Foundation also accounts for a sizeable NCD contribution; however, it only totals 1.8% of the organisation's overall health funding.[66] Contributions from regional development banks and specific bilaterals have increased (eg, from the UK and Japan)[67] and aid for health per capita has doubled, accounting for a quarter of lower-income countries' health spending in 2018.[66–69]

The percentage of DAH spent on NCDs by top bilateral donors (the UK, the USA, Germany, France, Canada and Australia) as a percentage of total DAH remains low, ranging from 1.4% to 2.5%.[66] An analysis of key policy documents found that only three countries specifically mention NCDs (Germany, France and Australia).[66] Earlier policy documents for the UK and the USA mentioned NCDs, suggesting that changes in political administration have reframed foreign and health policy measures.[66] While DAH has risen during the COVID-19 pandemic, additional funds have not been channelled to NCDs.[70]

Health expenditure from domestic public resources remains the dominant source of NCD spending in high-income countries but accounts for less than a quarter in low-income countries.[67] In 2018, increases in spending on health lagged behind overall growth in the gross domestic product (GDP), indicating that while economies were growing, spending on health was not keeping pace (figure 3).[62 68] Of the total spending for NCDs, domestic funds accounted for 37% in low-income countries and 59% in middle-income countries, while 2% of NCD funding comes from DAH in middle-income countries and 15% of NCD funding comes from DAH in low-income countries.[68] In the context of falling domestic health spending as a proportion of GDP and persistently low external funding, it is very difficult to fund NCD policies—especially those relating to health service delivery and medications. However, this pressure may increase the political feasibility of introducing revenue-generating policies such as tobacco and alcohol taxes—as has been done in countries ranging from Colombia and Costa Rica to Chad, Congo and Cabo Verde.[71]

POLICY IMPLEMENTATION IN COUNTRIES THAT HAVE EXPRESSED STRONG COMMITMENT

Reviewing commitments at the political, financial and programmatic levels highlights the need for additional work around the political economy of NCDs. While there is a correlation between member state engagement in the political processes of the HLMs and support to the overall NCD agenda—specifically from Uruguay, and as part of CARICOM, Trinidad and Tobago, Barbados and Jamaica—it is less clear how that translates into political prioritisation domestically and in policy implementation and financing. Both CARICOM and Uruguay were

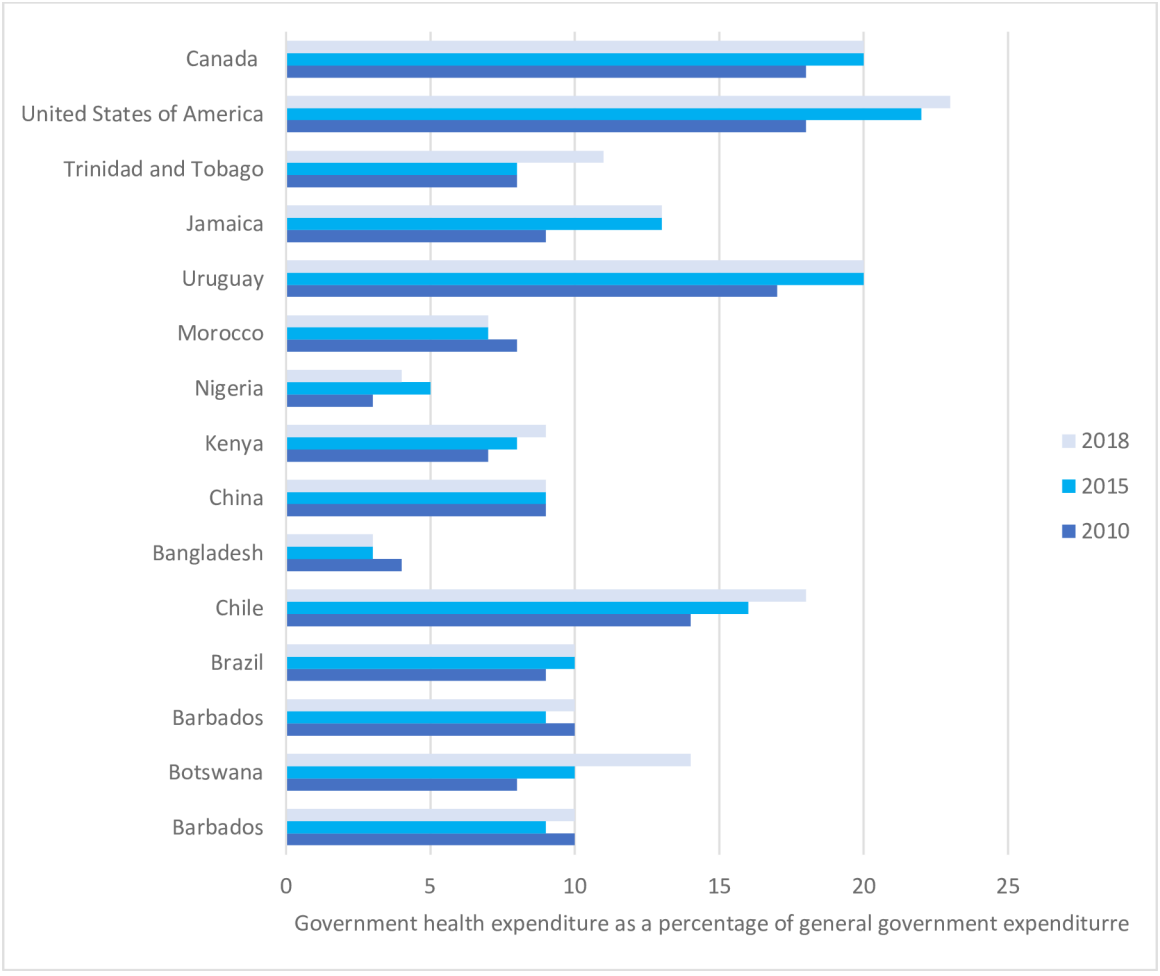

Figure 3 Domestic general government health expenditure as a percentage of general government expenditure.

active in the NCD agenda prior to the UNGA HLMs—Uruguay for instance was one of the pilot countries for a World Bank NCD Prevention Project started in 2007[72] and CARICOM held the first Head of State Summit on NCDs that same year—suggesting that NCDs already represented a political priority. Their continued commitment through engagement at the UNGA HLMs, both at the beginning when it sat in plenary as well as during the more interactive sessions in a parallel session, indicates that NCDs continued to be prioritised. Yet, the uptake of NCD policies in the region remains inconsistent. Translating prioritisation through expenditure is also not linear, as figure 3 suggests. In terms of donors, with low-income countries relying heavily on DAH, and increasingly on health aid, donors can end up indirectly influencing the priority-setting process for countries. While the implementation of policies is improving, national alignment to global strategies is not translating into policy, which suggests there are other factors at play.[73 74] Only 57% of countries indicated operational (and therefore funded) NCD plans, but how these are funded, what is funded and whether the approach has examined the most feasible interventions politically, socially and economically are less clear.[59]

THE ROLE OF 'POLITICAL WILL'

Despite strong evidence to support NCD interventions, implementation remains uneven. While many factors have been identified as impediments, including a lack of political commitment, insufficient data and funding, and industry interference,[75] these are still only partial explanations. To date, the focus has been on using global governance structures to achieve high-level political commitment to build national capacity. Yet, this focus has left less space to understand the successes and failures of NCD policies concerning the historical and current political economy, context and climate of the country, and how these impact outcomes.[76] Our analysis suggests that even head-of-state commitment expressed at the world's highest political forum is not sufficient to scale up action at home.

CONCLUSION

The landscape of international political commitments is complex and, as we have shown, does not necessarily correlate with national-level investment and policy implementation at home. If not particularly surprising, the fact that successive NCD HLMs have not been associated with meaningful rises in NCD funding is challenging. It also

bucks the precedent set by HIV/AIDs which saw large swings in political and financial commitment following the first HLMs—although again, it is difficult to isolate the impact of these meetings.

The HIV/AIDS pandemic saw a rapid rise in mortality among young people, requiring multisectoral action to address poverty and social determinants of health, community awareness and demand for services, and investment in diagnostics, clinical care and essential medicines—driven in large part by deeply engaged communities and activists who advanced rights-based arguments for action.[77] In contrast to HIV/AIDS, a major obstacle for NCDs is that it is a broad umbrella definition for a wide range of heterogeneous conditions, and patients commonly advocate for individual conditions rather than what is essentially a poorly framed technical term.[65 78] In drawing lessons from HIV/AIDS, Narayan *et al* identify strong surveillance and data collection systems, global commitments to research, the linking of detection and treatment programmes, and the mobilisation of a broader societal engagement as key lessons to support policy uptake for NCDs.[79]

While global NCD policy implementation has been rising slowly over time, it is notable that implementation is actually falling among countries that have been the most politically engaged with NCD HLMs. Further research should explore the challenges that these countries have faced in translating international political commitment into the mobilisation of domestic funds and a robust domestic policy agenda. We note that previous studies have identified a number of important factors that influence domestic policy-making including a focus on developing public support for change; political assessment of the actors, processes, potential partners and opportunities for advancing a particular policy goal; and engagement with policy design that specifically considers previous successes and failures in NCD policy implementation.[80–82] In their conceptual framework, Allen *et al* argue that domestic NCD policy implementation is predicated on policy-makers having the means (financial resources, competent and operational civil service) and motivation to act (driven by NCD prevalence, outcomes and corporate influence). These domains are grounded in national context; culture and society, politics and institutions, and geography. This model explains over 66% of the variation in global NCD policy implementation.[57]

One reason for slow- and in some cases stalling or declining action in some low- and middle-income countries (LMICs) may be that even though these countries face the most rapidly growing burden of NCDs, these conditions still cause less morbidity and mortality than maternal, neonatal and infectious causes. A number of WHO-recommended NCD policies also require complex, coordinated, multisectoral responses that can be difficult to sustain in the context of political volatility and inadequate resourcing.

Our findings have implications for NCD advocacy groups that invest significant resources in calling for continued high-level political engagement with NCDs at the United Nations. If these meetings do not necessarily translate into meaningful action, these energies may be better spent domestically in holding politicians to account and arguing for greater funding reallocation to match the burden of disease. However, we do not know the counterfactual, and in the absence of sustained international attention, NCD funding and policy-making might be even weaker. Rather than concluding that future HLMs should be disregarded, we would argue that greater attention needs to be paid to translating vaulting commitments into concrete action, sustainably funded in the context of limited resources. LMICs, fragile states and settings with constrained legislative and technical means may require additional support from WHO and other partners in this respect.

Our sense is that HLMs play an important role in galvanising high-level engagement from national leaders and serve as a vehicle for high-level advocacy on NCDs. To make the most of these meetings, other sectors need to be activated, and health advocates should focus on the supporting elements that link international declarations to funding decisions and the implementation of policies and programmes that make a difference to people and families around the world.

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Correction: *The impact of UN high-level meetings on non-communicable disease funding and policy implementation*

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In the published version the corresponding author changed to Téa E Collins from Luke N Allen. And updated the Competing interests and figure 3 caption as listed below:

Figure 3: Domestic general government health expenditure as a percentage of general government expenditure.

Competing interests :The authors alone are responsible for the views expressed in this publication and they do not necessarily represent the views, decisions or policies of the World Health Organization.

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