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

Arian Hatefi, Luke Allen

In years past, the face of the global burden of disease was a rural child suffering from 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 from multiple chronic diseases in a middle-income country. How could donors provide universal health coverage (UHC) or meet such an expansive need for healthcare 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 healthcare (figure 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).

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.

That burden is enormous. NCDs accounted for 73% of global deaths (40 million people) in 2016, of which 75% (30 million) were in low-income 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. Yet, NCDs attract only 1.7% of development assistance for health. 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 disability-adjusted life-years (DALYs) lost worldwide (15 million in LMICs). 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. The world’s poor suffer more from NCDs, are less able to access minimum quality care and are more vulnerable to catastrophic health expenditure.

**UNDE**

**STANDING 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 in LMICs 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.19 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.

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 healthcare system control; interventions in these domains generally do not produce measurable results in short time frames.

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 destabilising societies. 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 aetiologies, 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 globalise 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 fulfil their health systems’ obligations by globalising the benefits of relatively small investments. Yet they are grossly underprovided, 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, healthcare 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 policymakers 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, 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—for example, when states prioritise non-evidence-based approaches, cosy up to problematic commercial interests, suffer from despotic rule or inadequately prioritise 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 incentivise 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. The donor community can enhance pro-poor research and development investments targeted at middle-income countries (eg, through research supporting the implementation and scale-up of the WHO atherosclerotic heart disease programme, Global Hearts, into existing primary care infrastructures).

Third, efforts to reduce individual-level high-risk behaviours (eg, substance use, poor diet and physical inactivity) have not substantially reduced the NCD burden. Donors can refocus NCD prevention efforts on more cost-effective population-level interventions aimed at mitigating the globalisation of harmful substances (eg, 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 LMICs is a potential funding opportunity for donors.

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

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 politised 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, jeopardising 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.

Contributors AH conceived of and wrote the manuscript. LA provided valuable feedback and revision. Both authors agreed to the final version of the manuscript.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent Not required.

Provenance and peer review Commissioned; externally peer reviewed.

© Article author(s) (or their employer(s) unless otherwise stated in the text of the article) 2018. All rights reserved. No commercial use is permitted unless otherwise expressly granted.

To cite Hatefi A, Allen L. J Epidemiol Community Health Month 2018 Vol 0 No 0
REFERENCES

Hatefi A, Allen L. J Epidemiol Community Health. Month 2018 Vol 0 No 0