WHO Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases

Rethinking international cooperation for the prevention and control of noncommunicable diseases

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Dialogue on strengthening international cooperation on noncommunicable diseases

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Introduction

There continues to be a massive disconnect between the magnitude of the problems that will be caused now and in the future by noncommunicable diseases (NCDs) and the level of political, financial and technical resources available for their effective prevention and control.

The problem is no longer one of evidence alone. While NCDs do not threaten global security, as AIDS or other pandemics have been predicted to do, the potential negative economic externalities attributable to NCDs are hard to ignore.\(^1\) Similarly, the positive benefits of reducing the burden of NCDs in terms of poverty reduction are equally well documented.\(^2\)

There is a growing consensus that the main burden of financing the response to the challenge of NCDs will rest with national governments.\(^3\) Nevertheless, international cooperation – whether through North–South, South–South or other forms of assistance – can play an important role. The explicit inclusion of NCDs as a target of the Sustainable Development Goals enhances this potential.

However, in a post-Millennium Development Goal world, where the forces that shape development financing are also changing rapidly, there may be a need to rethink the role and objectives of international aid and challenge some of the prevailing orthodoxies on how it is used. This discussion paper reviews the changing landscape for international cooperation and explores some possible avenues and approaches for realizing the international cooperation commitments made at the United Nations General Assembly in 2011 and 2014.

Context

The odds are stacked against traditional donor financing for NCDs

While many donor governments are concerned *domestically* about the problem, NCDs are still not high on the agenda for their development cooperation agencies – nor for some of the major health philanthropies. The reasons are not hard to understand.

After the financial crisis public pressure on aid budgets has been intense. In some countries budgets have been savagely cut. In those where they have been protected, justifying expenditures to a sceptical public, themselves subject to austerity measures, is a continuing preoccupation. The central elements of a strategy to justify aid spending in these circumstances are clear: cut overheads to the bone; avoid any possible fiduciary risk; deliver

\(^1\) Current estimates suggest that cumulative global economic losses between 2011 and 2025 will surpass US$ 51 trillion.


\(^3\) http://who.int/entity/nmh/ncd-coordination-mechanism/Policybrief5.2docx.pdf?ua=1, GCM/NCD Financing Working Group Policy brief
attributable and quantifiable results, ideally in terms of children’s and women’s lives saved; and focus on the poorest and most disadvantaged countries.

Given these pressures, a continuing focus on a few Millennium Development Goal-related results – notably maternal, newborn and child health and communicable diseases – makes sense. In addition, health-specific global funds, such as the GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria, become increasingly attractive as funding channels: the transaction costs of periodic replenishment are low, the funds themselves take on much of the fiduciary risk, while their donors can associate themselves with their achievements.

In these circumstances, it is hard for NCDs to compete. In the absence of a new single-purpose fund (for which there is little donor appetite), transaction costs will be high. Changes in health outcome and exposure to risk will take time, and cannot be guaranteed (despite the availability of “best buy” cost-effective interventions). Moreover, the middle-income countries where the epidemic of NCDs is becoming most acute (and where solid results could influence spending more widely) are the countries where donor spending is reducing most rapidly.

To add to this: *even if* the seriousness of the problem is sufficient to overcome these reservations, and *even if* it is acknowledged that action beyond the health sector is as important as, or more important than, traditional health interventions, NCDs still have to compete within agencies for “health funds”. In both aid-receiving countries and donor agencies (and indeed in WHO) the traditional domains for donor funding – AIDS, tuberculosis and malaria; maternal, newborn and child health; and, to a lesser extent, health systems – all have active champions supporting existing programmes. Competing on these grounds is an uphill battle.

**The Sustainable Development Goals can make a difference**

This will be the first dialogue of the Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases (GCM/NCD) to be held after the new generation of global development goals have been adopted by the United Nations General Assembly. The inclusion of NCD targets under goal 3 is obviously welcome. However, the transition from Millennium Development Goals to Sustainable Development Goals cannot be seen just in terms of a longer list of goals and targets that now compete for resources. The Sustainable Development Goals are different, and it will be a wasted opportunity if the transition is seen purely in traditional fundraising terms. Moreover, the inclusion of target 3.4 does not require, as some have suggested, a completely new process of target setting. The four time-bound commitments previously made by Heads of State should remain the key focus to 2018.

Clearly, however, the default mode will be the development or further refinement of costing estimates (what will it take to achieve the targets?), and on this basis, with the backing of the new Sustainable Development Goal targets, to advocate a greater share of health funding at national and international level. The question is, given the pressures on development assistance noted above: will this traditional (Millennium Development Goal-style, competitive) approach make a real difference with bilateral and multilateral donors? The
evidence to date does not give great confidence that it will. Neither is there any guarantee that this type of approach will attract sufficient funds from the philanthropies or from new donors in rapidly growing economies.

There are however positive ideas to be taken from the Sustainable Development Goals in terms of new ways of working in the health sector, and greater legitimacy for cross-sectoral action.

**New ways of working in the health sector**

First, one of the key messages for health that emerges from an initial analysis of the Sustainable Development Goals is that achieving the new health targets cannot rely on business as usual. One of the problems of the Millennium Development Goal era was the fragmentation of country health systems that resulted from the establishment of separate programmes, each focusing on its own targets, with little consideration for the impact on the health system as a whole. This situation is exacerbated when each programme produces a separate estimate of financial needs, geared primarily towards advocacy rather than accurate budgeting.

With 13 health targets covering most national health concerns, an approach to national health development that focuses on individual programmes in isolation will be counterproductive. It risks even greater fragmentation and competition than has been seen in the past. It will also fail to address the many cross-cutting issues that do not fit neatly into programme areas. To respond to the new agenda, efforts to prevent and control NCDs need to contribute to, and work within, the framework of a country’s overall health plan or strategy. Developing a new, progressive, health sector strategy for addressing NCDs (see below) needs to be one of the pillars of a new approach to international cooperation.

**Increased legitimacy for cross-sectoral action**

The second key message from an analysis of the Sustainable Development Goals comes from the idea that they are “unprecedented in scope and significance” and designed to be “integrated and indivisible”. While the Millennium Development Goals were about a limited set of human development outcomes, the Sustainable Development Goals cover the economic, environmental and social pillars of sustainable development with a strong focus on equity. Although the breadth and ambition of the agenda has attracted critical comment, the range of topics covered in the Sustainable Development Goals more closely reflects the range of issues with which a government in reality has to contend than the narrow agenda encompassed by the Millennium Development Goals. The advantage for the NCD community (and particularly WHO GCM/NCD) is that this provides an unprecedented degree of legitimacy to pursue a more active agenda in relation to NCD determinants and risk factors through better governance for health.

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4 WHO. Health in 2015: from MDGs to SDGs. December 2015, chapter 9 – in press
The fundamental idea behind governance for health is that deliberate action is needed to influence governance in other policy arenas in order to promote and protect health. Areas of particular relevance, in which governance can have a positive impact on health, include trade and intellectual property (goal 17), sustainable energy (goal 7), urban development and human environments (goal 11), income inequality (goal 10), migration, food security (goal 2), and sustainable energy, consumption and production (goal 12).

The challenge will be to turn the potential for better governance for health provided by the Sustainable Development Goals into practical action.

**Rethinking international cooperation For NCDs**

The metric that seems to be of greatest concern to the NCD community is the small proportion of development assistance for health allocated to NCDs – currently estimated at 1.23%. This share has remained relatively constant in the face of an overall enlarging pie, but in absolute terms it is tiny.

However, if international financial cooperation is never going to be a major source of funding for the global response to NCDs, then the absolute amount identifiable as “NCD funding” in National Health Accounts may be less important than ensuring that any available funding is used to catalyse or leverage other sources of finance, and that development assistance for health delivers the desired results, irrespective of how it is labelled.

Given the importance of NCDs to the whole health agenda, the key metric therefore is increased expenditure on health, with NCD outcomes as the measure of effective spending.

**Leveraging national expenditure**

Historically, it is useful to think how international cooperation has shifted health sector priorities in the past. In many cases it has been through the purchase of commodities delivered to health systems in which operating costs are otherwise scarce, backed up by selective salary supplementation and some infrastructure spending. Three areas stand out where development assistance for health has made a real difference, sometimes in the face of early recipient government resistance: family planning, HIV/AIDS and immunization.

Only to a very limited extent are these options open to NCD funders. The cost of most commodities needed for the NCD best buys are low and thus not a limiting factor per se. Nevertheless, donor support for indirect costs such as prequalification, pooled procurement and market shaping can be influential. However, no donor is going to finance a new cadre of

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6 http://who.int/entity/nmh/ncd-coordination-mechanism/Policybrief5.2docx.pdf?ua=1, GCM/NCD Financing Working Group Policy brief

7 Remembering, of course, that one person’s influencing national strategic priorities is another person’s donor-driven budgetary distortion.
NCD workers (as they did in many Asian countries for family planning) or pay salary supplements, as many donors, notably the global funds, have done. Nor are donors likely to build separate NCD clinics (as happened in the early days of AIDS).

An alternative approach to influencing national spending priorities, currently used by some global partnerships in the interests of specific programme sustainability, is to insist that their grants are supplemented by national counterpart funding. Removing such specific requirements, thus allowing greater freedom of choice to allocate domestic resources, can increases governments’ room to manoeuvre to fund NCDs.

Overall, with few opportunities to leverage traditional forms of donor funding, it will remain important to continue to track the United Nations General Assembly commitment on official development assistance for NCDs. At the same, it is important to recognize the limitation of assessments based on following funds for NCD programmes. Increased funding for health in conjunction with improving NCD outcomes remains the best measure of success.

**NCDs and universal health coverage**

The background paper for the previous WHO GCM/NCD meeting made the point that the prevention and control of NCDs depend on a well-functioning health system. The WHO Director-General in her opening remarks highlighted the same point. However, one of the policy briefs for this dialogue suggests a degree of ambivalence: “To date NCD donor funding has been skewed toward general health services” [my emphasis]. One might be forgiven for getting the impression that financing for health systems strengthening is in competition with financing for “NCDs”. Were this to be the case, it would be most unhelpful.

Recent events have brought home to a much wider political audience something that those directly involved in public health have known for a long time. Good levels of population health are hard to achieve in the absence of a well-functioning health system. While it is clear that growing donor support for health systems strengthening currently owes as much to concerns about health security as it does for universal health coverage, it nevertheless represents an important window of opportunity.

NCDs, like HIV/AIDS, require a multisectoral response. However, again like HIV/AIDS, this should not preclude having a robust health sector strategy. Developing a practical health sector strategy means going beyond identifying cost-effective interventions and best buys. If a reduction in the burden of disease attributable to NCDs is to be an outcome of universal health coverage, then there is a significant amount of work to be done in defining as precisely as possible what health systems (at different levels, and in different national contexts) should be able to do.

A tighter specification of health system attributes needs to consider many factors. These include changes in service configuration needed to manage multiple NCD pathologies (of growing importance in ageing populations); patient record systems that promote continuity of care; provider payment systems that reward prevention and the maintenance of wellness;

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8 WHO. Health in 2015: from MDGs to SDGs. December 2015, chapter 9 – in press
financing policies that protect people requiring life-long treatment; more sophisticated referral systems; revamping medical education and staff training; reorienting primary and community care systems; developing new approaches to palliative care; promoting the use of self-monitoring to enhance a sense of patient responsibility; promoting the use of new technologies; patient-centred, rather than speciality-centred service design; and many more.

At a more general level, the NCD community has a role to play to ensure that community and home-based services are adequately financed and, as has been the case in many countries, rich and poor, that primary care is not underresourced at the expense of tertiary hospitals.

In summary, health systems strengthening is a potential growth area for international financial cooperation. The NCD community should seek to take advantage of this trend.

The limitations of national planning: a million mutinies now

For an outside observer writing about NCDs, the most striking factor is the extraordinary diversity of the agenda. Just talking about the need for a multisectoral response does not seem to do justice to the number of factors to be considered and the number of layers and moving parts involved. To quote the WHO twelfth General Programme of Work: “These range from environmental exposures to harmful toxins, diet, tobacco use, excess salt and alcohol consumption and increasingly sedentary lifestyles. These in turn are linked to income, housing, employment, transport, agricultural and education policies, which themselves are influenced by patterns of international commerce, trade, finance, advertising, culture and communications.”

Compared to similar global challenges – such as climate change – the NCD agenda does, however, have one advantage. Even if goals and targets are not binding, there is an agreement on what the world is seeking to achieve. The question is what comes next?

A growing number of countries now have national NCD strategies or multisector action plans. A rapid review of these strategies and plans suggests that they are for the most part technically comprehensive and conceptually elegant. However, they are remarkably similar (considering the diversity of national characteristics) and, given the limited managerial and financial capacities of many of the countries concerned, they are very ambitious and somewhat overwhelming. While such strategies may be necessary, it is fair to ask whether on their own they are actually sufficient (in terms of attracting resources or leading to action).

While national strategies set out all that should be done, is there not a case for shorter-term and more down-to-earth statements for what will actually happen? Obviously, the two approaches are not mutually exclusive. National strategies are particularly important in highlighting long-term capacity-building needs. But there is also a place for statements of intent that say: out of all the problems relating to NCDs, this is what we are going to do first; this is how much it will cost; and this is how it will contribute in the long term to agreed national targets. Such statements may be piecemeal and will definitely not be comprehensive;

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9 With apologies to VS Naipaul (and India).
but they should reflect the most urgent national priorities. Collectively, however, they can make a difference (the idea of the million mutinies in the title of this section) and their specificity can make them more effective for attracting resources. A possible parallel is the statements on intended nationally determined contributions currently being prepared for the Paris Climate Change Conference.

**Naming, shaming and blaming: social movements for resource mobilization**

The debate about international cooperation has tended to focus on the role of governments and large donors in providing financial resources. The arguments presented are rational, measured and reasonable, but is this enough? Getting over 15 million people on treatment for AIDS or forcing pharmaceutical companies to reduce the price of life-saving medication did not happen through reason alone. These achievements owe as much or more to activists who made what, at the time, seemed like totally unreasonable demands – for instance, to drop prices by 90% and to start thinking in terms of billions rather than millions of dollars a year as the required level of donor support.

The neglect of NCDs is not just an economic challenge – it is a global scandal. The paucity of services to treat cancer in a large part of the low-income world, for example, is shameful and unjust. The costs of some forms of treatment are artificially high, meaning that health care is only available to a minute proportion of the world’s population.

Because of its breadth and diversity, focusing the kind of moral outrage that can change the behaviour of governments and their development partners will be challenging. For campaigns to be successful they need to have a clear target and outcome: a chorus of competing interest groups (as is too often the case with the NCDs) will have little impact. Campaigns cannot therefore do everything. But activism has changed the behaviour of some companies (for example, in the food and drink arena) and could potentially do far more in bringing more resources to an area of global health that has been shamefully underresourced.

**Reduce the dependency on “health” funding: getting others to pay**

As noted in the introduction, NCDs tend to compete for health funds in donor agencies and international organizations and tend to be at a disadvantage when they do so. There is therefore a need to explore ways in which sectors that either stand to benefit from a reduction in NCDs, or that contribute to NCD risks, can bear a greater proportion of the cost of prevention and control (analogous to the “polluter pays” principle). Similarly, commercial entities benefit from the existence of global public goods such as normative standards in food safety and air quality, but are required to make no financial contribution to their production.

While maintaining the scientific and ethical integrity of organizations (such as WHO) charged with developing standards is critical, a more imaginative approach to diversifying sources of financing from commercial entities would seem to merit further exploration.
Making better use of technical expertise for addressing NCD risk factors and determinants

The discussion of international cooperation is relatively silent on technical cooperation. This point was made in the United Nations General Assembly 2014 review and highlighted by the WHO Director-General at the last WHO GCM/NCD dialogue meeting.

While most countries can draw on local health sector expertise, there is a dearth of practical experience that can guide governments on how best to work outside the sector on other NCD determinants and risk factors. Practical experience of the institutional and political pitfalls of working on regulatory issues, or liaising with industry and the corporate sector, is very valuable and not necessarily that expensive. It is also an area where South–South cooperation can be particularly important, given the need for hands-on expertise rather than major resource transfers.

Improving what is in effect an unregulated market in technical cooperation naturally has its own challenges. However, an independently accredited network of individuals and institutions that are free from actual or perceived conflicts of interest, and that can genuinely lay claim to practical experience (and not just at the level of advocacy and rhetoric), would be an asset of great value to many countries.

Conclusion

The wide range of actors and the commercial stakes involved in addressing the causes and determinants of NCDs make for a highly contested and politicized field, in which debate about setting global rules for engagement and coordination risks taking precedence over action on the ground. It is vitally important that the urge to control does not lead to paralysis and a professional community that speaks primarily to itself.

International financial and technical cooperation will always be secondary to domestic resources and local expertise. Nevertheless, if used creatively to leverage other resources, it has an important role to play.

If there is one broad conclusion to draw from this analysis, it is that the NCD community has been remarkably successful in creating a robust normative framework for action – globally and in individual countries – with clear end points for what needs to be achieved. But now is the time for that action to take place.

Momentum is critical. Work may not progress according to well-designed strategies and plans. It is may be messy, fragmented and piecemeal, but change is possible and can be cumulative. For this to happen requires that the NCD community is prepared to reach out. Catalysing change, exchanging experience, and bringing in expertise from a wide variety of sectors and disciplines will all be critical. It is also in these areas that international cooperation, from all points of the compass – north, south, east and west – can be of continuing value.