WHO Global Coordinating Mechanism on the Prevention and Control of Noncommunicable diseases (GCM/NCD)

Bilateral and Multilateral Financing

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Levels and trends in NCD external funding

NCDs accounted for 1.2% of all development assistance for health (DAH) in 2011, or US$377 million (1). While still tiny, NCD donor funding from official sources is growing roughly proportional to overall DAH. The ten-year trend shows almost a tripling of DAH for NCDs, from US$129 million in 2000, and a parallel near-tripling of overall DAH, from US$11 billion to US$31 billion in the same period.

NCD funding by disease area

Earlier data (2) showed that the largest segment of donor funding is non disease-specific “general non-communicable disease funding.” Among disease-specific funding, tobacco received the most funding, followed by obesity, sense organ diseases, diabetes, and mental health (2). Tobacco control DAH quadrupled from 2005 to a peak of approximately $100 million in 2010 primarily due to efforts by the Bloomberg Foundation and the Bill & Melinda Gates Foundation.
NCD Funding by channel
Multilaterals (including the EC) are collectively the largest source of NCD funding, providing 45% of overall external support in 2011 (1). The World Bank provides 30% of the total, making it the largest individual NCD donor. NGOs as a group provide $100 million for NCDs in 2011. This category includes organizations that receive substantial funding from the USA government, as well as individual charitable giving.

NCD and overall global health funding channels
Bilateral donors are the dominant funding source in global health overall, providing 52% of overall DAH. The World Bank and WHO each provide 9% of funding for DAH (1). In sharp contrast, bilateral donors provided only $40 million or 11% of DAH for NCDs in 2011 (3).
NCD funding by recipient region
Most NCD donor funding is not regionally targeted. Where there is geographic targeting, donor funds for NCDs are concentrated in regions that showed an earlier rise in NCDs and their risks (obesity, tobacco use), such as Western and Central Asia and Latin America and Caribbean (1).
Bottlenecks in bilateral and multilateral funding for NCDs. Lack of funding interacts with limited and fragmented advocacy and a weak evidence base of proven, cost-effective interventions to create a vicious cycle (4). Additional factors include: (a) the lack of immediate risk to others from NCDs (5); (b) the high cost and possible futility of NCD interventions; (c) low capacity and preparedness of developing countries; and (d) the placing responsibility for addressing NCDs elsewhere.

Awareness of the importance of NCDs(6). Progress in NCD-related advocacy and governance (7).

Improved evidence for proven cost-effective interventions, policies and system actions (8,9).
MOTIVATION for donors to act on NCDs appears to be an economic argument—that developing country economic growth and health system stability are undermined by continuing neglect of NCDs (10,11).

To demonstrate FEASIBILITY and create URGENCY, policy champions can help overcome an underdeveloped advocacy network, and galvanize other actors, including donors (12). Evidence-based policy proposals are an important stimulus to donor governments, especially when they come from respected institutions in their own countries (10,13).

Recipient countries can strengthen requests for assistance to support prevention and control of NCDs by adding NCDs to strategic priorities, both in national development plans and in health sector plans. Beyond plans, concrete steps are needed to define financial and technical assistance needs.
Learning from experience

Funding for diagonal approaches (sometimes called integration) is growing (14). Some donors are supporting new health care delivery methods that focus on community-based or inter-disciplinary providers (10). Among these are: integrating NCD care with other chronic disease programs like HIV/AIDS and Tuberculosis; integrating NCD care with patient and population-specific programs, such as maternal and child health; and including NCD care in primary health care delivery (15,16).
Future Considerations

Donor funding does not always align closely to disease burden (1,2,10). At left, the shares of burden of disease (measured by disability adjusted life years) and total DAH for a selection of diseases are shown. The largest gap between burden and funding is for NCDs. These conditions constitute 50% of the global disease burden but received just over 1% of DAH in 2011.

WHO and others (17,18) projected that US$11.4 billion is needed annually to carry out NCD “best buy” interventions in all LMICs. The current level of NCD DAH (US$377 million) is 3.3% of this estimated need. We calculate that donors could meet 10% of annual NCD needs by providing a mere $1.1 billion annually for NCDs, or a 200% increase over current levels, and only 3.5% of total DAH (2011 value).
References


