WHO global coordination mechanism on the prevention and control of noncommunicable diseases

Working Group on how to realize governments’ commitment to provide financing for NCDs

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Policy Brief

Bilateral and multilateral financing for NCDs

by

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This document was prepared by Dr Rachel Nugent. The author is responsible for the views expressed in this publication. This document does not represent an official position of the World Health Organization. It is a tool to explore the views of interested parties on the subject matter.
This policy brief is one of three relating to the commitment by Heads of State and Government at the High Level Meeting of the UN General Assembly on the Prevention and Control of Noncommunicable Diseases in September 2011 to explore the provision of adequate, predictable and sustained resources, through domestic, bilateral, regional and multilateral channels, including traditional and voluntary innovative financing mechanisms. A separate discussion paper summarises lessons learnt to date and possible approaches to support Member States to realize this commitment. All papers are available on the website of the WHO global coordination mechanism on the prevention and control of noncommunicable diseases (GCM/NCD) http://www.who.int/nmh/ncd-coordination-mechanism/en/.

This policy brief on bilateral and multilateral financing for Noncommunicable Diseases (NCDs) provides a situation analysis of bilateral and multilateral funding for NCDs, a synopsis of bottlenecks and constraints facing donor countries when it comes to funding NCDs in Low and Middle Income Countries (LMICs), and ways and means to overcome the challenges and issues for consideration.

**Summary**

- 63% of countries see international donors as an important source of funding for NCDs, but country requests for donor assistance are mostly unheeded
- NCDs receive the smallest amount of donor funding of all major global health areas, accounting for only 1.23% of all donor assistance for health (DAH) in 2011
- Funding sources for NCDs are diversifying but, to date, bilateral donors have been largely absent
- Non-ODA funders appear to be as important as ODA funders currently.
- To date, NCD donor funding has been skewed toward general health services and tobacco control.

1. **Situation analysis**

This section details the level, trends, geographical, and disease distribution of this funding to the extent permitted by available data.¹ The funding landscape for NCDs is changing rapidly, with most donors being relatively new to the field, and even more incipient.

1) **Levels and trend in NCD external funding**

NCDs accounted for 1.2% of all DAH in 2011, or US$377 million (1).² 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

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¹ In this brief, NCDs includes spending on tobacco prevention and control unless otherwise noted.
² All amounts are in 2011 US $, unless noted.
parallel near-tripling of overall DAH, from US$11 billion to US$31 billion in the same period (Figure 1).

Figure 1: Total DAH (right-hand scale) and NCD DAH (left-hand scale)

2) Sources of NCD external funding

Multilateral organizations (including European Community) 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. The WHO provides 13% of NCD DAH.

Figure 2: Shares of funding to NCDs provided by each major donor source.
Bilateral donors are the dominant funding source in global health, providing 52% of overall DAH. The World Bank and WHO each provide 9% (1). In sharp contrast, bilateral donors provided only $40 million or 11% of DAH for NCDs in 2011 (2). NGOs as a group provide $100 million for NCDs -- almost as much as multilateral organizations provide, and far more than bilateral donors. This category includes organizations that receive substantial funding from the USA government, as well as individual charitable giving. Other non-official sources -- non-US-based charities, private for-profit sources, and research funding – provide funds to developing countries for addressing NCDs, through capacity-building, knowledge-building, and service provision (3). These are not included in the databases cited above (2).

3) NCD funding by 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.

4) NCD funding by disease

The most recent available NCD donor data are not disaggregated by disease. Earlier disaggregated data (3) showed that the largest segment of donor funding is non-specific “general non-communicable disease funding.” Of those funding streams with a specific disease or risk factor specified, tobacco received the most funding, followed by obesity, sense organ diseases, diabetes, and mental health. Alcohol, and kidney disease received the lowest amount of funding (3).

Tobacco control DAH increased from $23 million in 2005 to a peak of approximately $100 million in 2010. In 2011, 51% of tobacco DAH was contributed by the Bloomberg Foundation, 22% came from the Bill & Melinda Gates Foundation, 18% from USA NGOs, 9% from WHO, and less than 1% from other bilaterals (2). Because the contributions from the two major foundation donors account for the majority of total NCD funding, there are large fluctuations from year to year in funding. Table 1 shows changes in tobacco and other NCD funding from 2000 to 2011.

Table 1: Total DAH for NCDs and tobacco-related DAH, 2000-2011

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<tbody>
<tr>
<td>Tobacco Funding</td>
<td>120</td>
<td>125</td>
<td>127</td>
<td>114</td>
<td>95</td>
<td>170</td>
<td>185</td>
<td>268</td>
<td>209</td>
<td>263</td>
<td>260</td>
<td>310</td>
</tr>
<tr>
<td>Other NCD Funding</td>
<td>8</td>
<td>10</td>
<td>18</td>
<td>38</td>
<td>23</td>
<td>24</td>
<td>25</td>
<td>55</td>
<td>71</td>
<td>108</td>
<td>101</td>
<td>68</td>
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Reasons for the strong support for tobacco prevention and control include the clarion call for tobacco reduction expressed in the Framework Convention on Tobacco Control (FCTC), the powerful advocacy emanating from cancer control organizations, and an agreed set of clear and measurable interventions in the WHO MPOWER Package.
5) Data limitations

Donor funds for NCDs are likely higher than official figures indicate. Almost 40% of the total DAH identified in (1) are categorized as “unallocable” or “other,” and another 4% is “health sector support.” Some of this supports NCDs. We find evidence of this through a more granular examination of the data\(^3\), allowing us to identify where general health projects included funds for NCDs that is not apparent in the high-level accounting (3). Through this method we estimated external funding for NCDs at about 2.5 times the amount identified in (1) in 2008.

Second, some sources of DAH are not included in the Institute for Health Metrics and Evaluation and OECD/DAC/CRS databases (2), such as the growing donor funding from BRICS and Arab States. Although the size and purpose of those sources are not currently known, the BRICS group has officially stated its intention to emphasize non-communicable diseases (4). Charitable assistance from non-USA charities is also omitted from the databases, as is funding from the private, for-profit sector. The private sector is actively funding pilot programs, advocacy, and implementation research on NCDs in LMICs (5). Finally, research funding for NCDs in developing countries is significant (2, 3, 6).

2. Synopsis of bottlenecks and constraints facing donor countries in allocating resources for NCDs

Several factors create 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. This was the picture prior to the commitments made at the UN General Assembly High Level Meeting in 2011 (7). Other reasons articulated by donors for shying away from making major investments in NCD prevention and control include: a) the lack of immediate risk to others from NCDs, an argument effectively employed to promote action against infectious diseases (8); (b) the high cost and possible futility of NCD interventions; (c) low capacity and preparedness of developing countries to respond to the NCD epidemic; and (d) the sentiment that the responsibility for addressing NCDs lies elsewhere.

Most of these bottlenecks and arguments are eroding, albeit slowly. Awareness of the importance of NCDs has risen dramatically in three years, largely because of the U.N. General Assembly High Level Meeting and the growing NCD burden of disease (2, 9). Progress in advocacy and governance is occurring at a fast pace (10). For example, the NCD Alliance has become the source of global NCD advocacy, harnessing the efforts of more than 2,000 organizations, and spawning country- and regionally-based NCD Alliances (11). Other public health and professional societies as well as the private sector are involved in raising awareness and sponsoring pilot projects and capacity-building in developing countries (12).

However, to stimulate NCD funding, advocacy and activism will need to become more broad-based and grassroots, both in donor countries and in recipient countries, following

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\(^3\) A hand-search was done of the OECD and Foundation Center databases to identify NCD funding through narrative project descriptions. For large funders, a follow-up direct contact was made to confirm findings.
the successful model of HIV/AIDS. An NCD example inspired by successful campaigns in infectious diseases, the Pink Ribbon Red Ribbon initiative promotes cervical cancer and breast cancer awareness, screening and treatment (13). More NCD initiatives of this sort are needed. Championing NCDs primarily at the global level will not be sufficient (5).

The evidence for proven effective and cost-effective interventions, policies and health system strengthening actions at the country level is still perceived to be weak (14). This perception is not completely valid as both experience and modelling studies have demonstrated health improvements are attainable (15, 16, 17, 18). But empirical results from LICs are scarce as few countries have instituted all of the key policy actions (19) and even fewer have implemented a range of NCD services at scale (20). In addition to lack of funding, a significant barrier is that many countries are guided by the MDGs and therefore are still striving to attain better outcomes for infectious and maternal and child conditions.

3. Ways and means to overcome the challenges

1) Making the case for international action for NCD prevention and control

Donors are committed to global health. The long-term trends in DAH are solid, and new donors are coming on the global health scene. However, despite requests from recipient countries to broaden their lens to the growing problem of NCDs, donors have largely confined their substantial commitments to improving child and maternal health and reducing the burden of infectious diseases. A stronger sense of international responsibility for NCDs will emerge when bottlenecks described in section two are adequately refuted and the following conditions are present:

- Motivation
- Feasibility
- Urgency
- Collective action

Increasingly, the 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 (5, 21). This threat becomes more imminent as the NCD burden of disease increases (9).

To demonstrate feasibility and create urgency, policy champions can help overcome an underdeveloped advocacy network, and galvanize other actors, including donors (22). Evidence-based policy proposals are an important stimulus to donor governments, especially when they come from respected institutions in their own countries (5, 23). Donor countries will be more inclined to respond to recipient country needs when their own interests – political, economic, and diplomatic – are at stake (5, 23). Arguments put forth by academic experts and think tanks can directly influence political actors in a way that bureaucratic efforts cannot, and can underlay the development of a targeted strategy which can also be a challenge for bureaucracies with competing interests (24).
Finally, recipient countries can take several steps to assure donors of value for money and accountability for NCD donor assistance. 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 that are carefully aligned with other funding flows into the health sector and with the health needs of country populations, country capacity to deliver the NCD “best buys” and other cost-effective services, and the means to measure outcomes.

2) Learning from experience

Funding for diagonal approaches (sometimes called integration) is growing (25). Some donors are supporting new health care delivery methods that focus on community-based or inter-disciplinary providers (5). 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. New evidence points towards positive synergies that will improve patient outcomes (26, 27).

The diagonal approach recognizes that concurrent improvements in the health system itself are needed for effective disease prevention, i.e. in developing health workers, improving financing systems, increasing efficiency in drug supply chains, etc. Dialogue across programme areas also provides opportunities for learning from the successes and failures of HIV/AIDS and TB care and treatment.

4. Issues for consideration

1) NCD external funding relative to resource requirements

Donor funding does not always align closely to disease burden. NCDs receive a far smaller share of funding than their share in disease burden (1, 5, 28, 29, 30). Figure 3 shows the shares of burden of disease (measured by disability adjusted life years) and total DAH for a selection of diseases. HIV/AIDS represents 4% of global burden of disease and receives the largest share of funds at 33%, while the proportion of DAH for maternal, newborn, and child health at 22% of DAH is closely aligned with the disease burden of 21%. 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 (31, 32) 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 provide 10% of annual NCD needs by providing a mere $1.1 billion annually for NCDs, or a 200% increase over current levels (details in Appendix 1). This suggests two points. First, external funders can provide 10% of the funds needed to provide an essential NCD package in all LMICs for just 3.7% of current total DAH. Second, even with the greater effort that donors are expected to commit to NCDs, the majority of funding for NCDs will be required to come from national budgets.

2) Definitions, quality and tracking

Because donor funding for NCDs is a relatively new phenomenon, there are not clear and uniform protocols and definitions for reporting. Taking into account that current ODA for NCDs cannot be mapped and tracked, Ministers at the UN General Assembly in New York in July 2014 invited OECD/DAC to consider establishing a creditor reporting system code for NCDs.

3) Coordination mechanisms

Strong advocacy and evidence will prompt new funding for NCDs. Including NCDs in the post-2015 development goals will add momentum and focus (33). Countries identifying NCDs as strategic priorities in health sector plans and having ownership of such programmes will also substantiate the importance of investing in NCDs. But funds alone are not enough. Countries need to simultaneously build health system capacity across the board as the means to promote better overall health and prevent many NCDs and related diseases, and donors need to coordinate among themselves and with recipient countries. Multilateral bodies should serve as coordinating venues, and national health strategies should be used to provide donors with clear governmental priorities for NCD capacity building.
Programmatic coordination at the country level was recommended in Paragraph 30 of the U.N. General Assembly Outcome document (10). Donors can use health systems strengthening investments in infrastructure and human resources to ready health delivery platforms for NCD prevention and control, and incrementally add services. Further, donors can fill gaps in domestic NCD investments. In countries that do not yet have sufficient fiscal space to provide basic NCD services, they can lead the way. Finally, official donors should seek appropriate venues for sharing strategies and, in some instances, combining forces with the private sector, which has demonstrated its important role in filling some NCD needs in LMICs (34).
References


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Appendix 1: Author calculations of NCD funding need to meet NCD resource needs

The table below illustrates NCD DAH required for marginal increases in the percentage of resource requirements covered by external sources. Column A shows the % of $11.4 billion covered, Column B shows the corresponding absolute amount of funds in $USD millions, Column C shows the corresponding increase in $USD millions from 2011 levels of NCD DAH, and Column D shows the % increase from current levels of NCD DAH.

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<th>(A)</th>
<th>(B)</th>
<th>(C)</th>
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<tbody>
<tr>
<td>3.30% = current NCD DAH</td>
<td>$377</td>
<td>0</td>
<td>0%</td>
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<tr>
<td>4.00%</td>
<td>$456</td>
<td>$78</td>
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<tr>
<td>10.00%</td>
<td>$1140</td>
<td>$762</td>
<td>202%</td>
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\[1\] Data are primarily drawn from the IHME 2014 summary of development assistance for health (DAH). Sources for that report are the OECD/DAC Creditor Reporting System, financial reports and databases of multilateral organizations, and the US-based Foundation Center database and tax statements of foundations. This captures funding from bilateral agencies, the EC, development banks, UN agencies, and US foundations. The focus is on recent data. Additional data on corporate giving and research funding in developing countries are presented from a Center for Global Development 2010 Working Paper which provides a dated, but broader view of funding sources and disease-specificity.