

## **The role of development assistance in NCD and mental health finance**

### **Technical paper #2**

Technical background papers have been developed by a team of staff from the WHO, the World Bank and the University of Washington with the input of contracted consultants, as needed; all papers have benefited from the review and feedback of an External Technical Expert Group appointed to support the International dialogue on sustainable financing for NCDs and mental health. The papers will undergo further review by the WHO and the World Bank; therefore, they do not represent the official positions of both organizations. The papers are the property of the WHO and the World Bank. They may only be downloaded for the purpose of this web consultation and their content cannot be used for any other purpose.

## Key messages

- NCD and mental health conditions have, historically, struggled to attract Development Assistance for Health (DAH) for several reasons, yet there is evidence of a recent uptick in spending, driven by major philanthropies and development banks. In the current environment, new DAH for NCDs and mental health will probably go towards projects that can make a clear link to global priorities, including climate change and health emergency preparedness and response.
- While DAH cannot substitute for domestic finance, it can be used to accelerate progress by overcoming local implementation barriers. We propose a general approach to developing “catalytic” projects to address these barriers. Some settings pose unique challenges (e.g., LICs, humanitarian settings) and DAH for NCDs and mental health in these settings will look more like traditional DAH and framed as support for primary healthcare.
- An important role for DAH is to finance collective action on transnational problems. For NCDs and mental health, opportunities include coordinated efforts to control tobacco and other unhealthy products, air pollution (across borders), and access to medicines. Financing of policy and implementation research on NCDs and mental health—operationalized through multi-country “learning networks”—could also be a priority for some funders.

## Introduction

Development assistance is typically defined as the transfer of resources from wealthier to poorer populations to support economic development, often through official government channels. Development assistance for health (DAH) is the transfer of resources with a focus on improving health outcomes. DAH is usually conceived of more broadly than official development assistance to include funding from non-state actors (e.g., philanthropies). In the current era, DAH is a significant source of funding for health programs in numerous low-income countries (LICs) and some lower-middle-income countries (lower-MICs), although it only accounts for 30% or less of health spending even in the poorest countries, with governments and households accounting for the vast majority.<sup>1</sup>

The predominant frame for DAH is to support progress on “diseases of poverty,” often with a focus on communicable diseases, child health, and reproductive and maternal health. However, with the increasing interest over the past decade on noncommunicable disease (NCD) and mental health conditions in LICs and MICs, various groups have called for existing forms of DAH to pivot towards these conditions and for new DAH funding streams to be established.<sup>2</sup> Unfortunately, DAH has remained relatively flat since 2010, except for an uptick in 2020 and 2021 that can largely be attributed to financing the COVID-19 response.<sup>1</sup> Looking at recent history poses fundamental questions, including: (i) is it reasonable to expect DAH to increase in the current geopolitical climate of waning internationalism? (ii) is it fair to expect existing DAH, and/or a share of new DAH (if it emerges) to be allocated to NCD and mental health activities? (iii) if so, what sorts of things should DAH support?

While this paper does not provide definitive answers to these questions, it does seek to outline the ways

in which DAH could be more effectively channeled towards priority NCD and mental health activities, should the opportunity emerge. It also explores the perennial question of why these conditions have not captured the hearts and minds of donors. As an input to the International dialogue on sustainable financing NCDs and mental health, it seeks to structure the discussion at the International financing dialogue around how DAH can play an important *catalytic* role in the global and national responses. The hope is that the International financing dialogue will lead to a series of recommendations for potential donors and recipient countries that help make the most of available funding.

## Section 1: How much DAH is being channeled to NCD and mental health activities?

In recent years, several studies have produced estimates of DAH for NCD and mental health conditions. The largest is the Financing Global Health study from the Institute for Health Metrics and Evaluation, which is updated on a regular basis.<sup>3</sup> According to IHME, NCDs (including mental health) received 1.6% of DAH, with 20% of this share (i.e., 0.32%) dedicated to mental health. Table 1 presents the amounts of DAH for NCDs and mental health by donor. The landscape of funding for both NCDs and mental health is fragmented, with no dominant funders. Of note, “other sources” apart from bilaterals and private philanthropies constituted the plurality of funding for NCDs, and private philanthropies constituted most of the funding for mental health. Major bilaterals only contributed US\$ 230 million (21%) of all DAH for NCDs and mental health.

**Table 1** DAH for NCD and mental health conditions in 2021, by donor.

Financing source	NCDs		Mental health conditions	
	Absolute spend (US\$, millions)	Share of total spend	Absolute spend (US\$, millions)	Share of total spend
Other sources	350	40.0%	9.4	4.4%
Private philanthropies	150	17%	130	58%
BMGF	81	9.3%	5.0	2.3%
UK	58	6.7%	18	8.3%
US	20	2.4%	17	7.9%
Japan	14	1.7%	0.31	0.14%
Germany	31	3.6%	7.5	3.5%
France	21	2.4%	5.1	2.4%
Canada	28	3.3%	3.8	1.8%
Australia	6.7	0.78%	0.25	0.12%
Other governments	110	12%	25	12%
Total spending	860	100%	220	100%

Unlike conventional DAH to support “unfinished agenda” conditions (e.g., communicable, maternal, perinatal, and nutritional diseases), funding for NCDs and mental health supports a wide range of projects and interventions. For example, a US\$ 50 million program announced by Bloomberg Philanthropies aims to provide civic solutions to global issues such as mental health, affordable housing, and climate change. Vital Strategies (supported by Bloomberg) has also founded a Partnership for Healthy Cities. Significant funding is going towards other NCDs beyond the “Big 4” diseases featured in the Global Action Plan, e.g., a US\$ 26 million project to support cataract treatment in 11 countries.

But underneath the published figures are substantial ambiguities and methodological limitations, including a lack of a universally agreed-upon definition for interventions targeting NCDs. For instance, according to IHME, Canada allocated approximately CAN \$3.84 million to mental health programs in 2021. However, during the same period, the Canadian government committed USD \$15.9 million to the United Nations Population Fund (UNFPA) to support the scaling up of essential health services in conflict-affected regions, including clinical management of sexual assault, mental health and psychosocial support, and protection from sexual exploitation and abuse. The discrepancy in funding allocation underscores the complexity in tracking and disaggregating DAH contributions for specific diseases and interventions, highlighting the need for standardized definitions and reporting mechanisms to improve transparency and accountability in health financing efforts.

Because of methodological limitations, there is good reason to believe that the published studies on DAH significantly underestimate DAH for NCD and mental health. The main methodological challenge is that much of DAH goes towards cross-cutting health system strengthening projects that have benefits to NCD and mental health programs among others. For example, IBRD supports the Tamil Nadu Health System Reform Program (US\$ 52.7 million), which aims to “improve quality of care, strengthen management of non-communicable diseases and injuries, and reduce inequities in reproductive and child health services in Tamil Nadu.” How to appropriately allocate this US\$ 52.7 million to NCDs vs. reproductive and child health is an open question. Our desk review of IBRD projects suggests that around 30% of IBRD commitments in 2022 addressed NCDs partially or indirectly through health system reform.

Still, the World Bank is also stepping up its investments in NCD-specific projects. For example, Colombia received a US\$ 150 million loan focused on improving the quality of breast cancer care. Another US\$ 750 million loan to Colombia for development policy financing included specific support for the country to implement its so-called “junk food law” that was passed in 2022.

What is clear is that better and more timely tracking of NCD- and mental health -related DAH is necessary. Existing datasets, such as the OCED’s Creditor Reporting System, are difficult to parse. Methodological improvements are also required to better allocate DAH to specific conditions while recognizing the risk of double-counting. As the DAH ecosystem expands beyond traditional development partners, including a proliferation of private-sector actors interested in NCDs and mental health, it will be critical to put in place a rigorous system of tracking spending on these conditions to improve transparency, accountability, and coordination of spending.

## Section 2: In what ways has global commitment to NCDs and mental health translated into increased international financing and how do we capitalize on these lessons?

A starting point for the discussion on increasing NCD- and mental health-related DAH is to understand how global and national actors understand the NCD and mental health agendas (and their role) and what factors are hindering increased investment. To answer this question, we conducted in-depth interviews among stakeholders from a range of international organizations. The Methods Annex [to be written] provides additional details. The emerging findings below are based on analysis of the first 19 interviewees, who represent a range of philanthropies, multilateral organizations, and other partners.

### *How the politics of NCD and mental health affect their place in the global health agenda*

The WHO has been the primary advocate for NCD and mental health action at the global level for the past three decades. This has been a consequence of the divergence of the NCD and mental health from that of “unfinished agenda” conditions, but it has also exacerbated that divergence in several specific ways.

First, the NCD conversation has stayed very much in the technical/technocratic space. There is a lack of counterpart actors in the other dimensions of agenda-setting, e.g., advocacy, policy champions, rights (with mental health being an increasing exception), and development. There has also been no emergence of a clear set of ‘anchor donors’ from the global north, analogous to what was seen for the unfinished agenda conditions. An upshot of these developments is the lack of sufficient cross-fertilization between those with financing expertise and those with health expertise.

Second, the first International financing dialogue was a WHO-led initiative. Interviewees perceived the lack of significant engagement with development banks, development agencies, ministries of finance, and the private sector as being a significant barrier to the uptake of the recommendations from the first global dialogue. On the other hand, interviewees saw the deep involvement of WHO in the preparations for the International financing dialogue as a sign of progress and an important opportunity. Ministries of finance were seen as critical to engage actively in the International financing dialogue, because their sign-off would be needed for virtually any new NCD or mental health initiative (e.g. a health tax, an expansion of insurance, or a loan request to the World Bank). Some interviewees expressed a strong view that NCD and mental health financing efforts should be driven by countries, with support from a constellation of regional and global UN bodies and development partners, and that it should not be solely driven by Geneva-based organizations.

Third, the push for action on NCDs and mental health has been couched within the broader agenda on primary healthcare and universal health coverage. While there are merits to this framing there are also some risks.

On the merits side, UHC is seen as having a strong political moment in the context of the SDGs. Rhetoric

around and renewed attention to primary healthcare has also increased over this timeframe, including from development agencies. Of course, there are technical reasons why financing for these conditions makes sense as part of an integrated agenda for health and UHC. From the perspective of domestic finance, vertical NCD and mental health programs and financing streams are neither efficient nor sustainable. By this logic, DAH for NCD and mental health should be channeled to general government budgets and (mostly) pooled with other domestic health spending. Furthermore, the creation of targeted funding streams would only reinforce the practice of mental health and NCDs silos and their exclusion from the global health agenda setting and from consideration within health benefits package design. Donor fatigue and shrinking budgets in both national and global health financing are driving advocacy efforts towards greater integration.

On the risks side, it is clear that the UHC agenda is stalling, with most countries way off track on most UHC-related indicators (including financial protection) halfway through the SDG period. Some interviewees proposed that integrated NCD and mental health activities into existing funding schemes (e.g., the Global Fund) would be a more effective way of “getting money quickly to where it’s most needed” as compared to a fully integrated approach. Additionally, targeted funding streams are easier to track compared, e.g., to looking at NCD and mental health spending within the NHA envelopes for domestic resources. “What gets measured, gets managed” is a truism for good reason. Integration also necessitates that policy systems, as well as general health service delivery infrastructure, are prepared for integration, for example, ensuring technical capacity exists to operationalize the objectives of shared funds. Otherwise, according to one interviewee, “you will end up with basic care packages... because there's no, for example, knowledge on how to cost [NCD- and mental health -related programs] generally.”

### ***Characteristics of the policy response on NCDs and mental health conditions***

NCDs are currently a story of the inversion of the global health model. Advocacy, donor, and development bank interviewees separately noted that requests for support and interest are coming from countries, in the absence of a strong agenda being pushed by donors. This is a positive development that mitigates against the colonialist legacy of DAH. Many countries (particularly MICs) appreciate and accept the importance of getting the NCD response right to help control health spending in the long run.

Further, interviewees stressed the importance of focusing on things that are going well. Positive developments at the country level run the risk of getting buried in the “woe is us” pronouncements of advocacy organizations that there is not enough money for NCDs and mental health. A better frame and a stronger message is that funds (even modest ones) have been thoughtfully put towards NCD and mental health efforts, and they have often achieved notable impact. Examples cited by interviewees include (i) implementation of tobacco tax policies in North Macedonia, (ii) workforce development in Liberia, and (iii) cervical cancer screening in Uruguay.

Following the agendas of country governments was also seen as preferable to global health organizations driving the timeline and agenda. The former builds credibility and makes the value argument easier.

International support has been most effective when aligned with revisions to national strategic plans; however, this requires international organizations to have readily available national expertise across core policy dimensions (e.g., general policy timeline, financing mechanisms, and technical knowledge of NCD and mental health interventions). The operational approach of the Health4Life Fund, which has a steering committee led by implementing countries (Kenya, Thailand, Uruguay), could be replicated/adapted and scaled.

### *Articulating the NCD and mental health “problem” stream*

A major difficulty in agenda-setting for NCDs and mental health is effectively “problematizing” these conditions in a way that spurs action. Interviewees identified three main areas for progress on this area.

First, the complexity issue is a major challenge, and the “global agenda” needs to accommodate this complexity rather than sidestep it. NCD and mental health conditions are complex problems, despite decades of attempts to simplify them (Herrick, 2022). The intersection between varied disease burdens, health systems maturity, and political economy creates a unique dynamic in each country. One way forward is to place greater emphasis on regional rather than global approaches. Regional approaches take advantage of cultural and health system similarities (including in terms of financing), greater relevance of data, more rapid response times, and easier coordination. Most regions have strong bodies (e.g., WHO regional offices, regional development banks) that are capable of merging technical expertise with funding, provided globally available resources are allocated fairly across these bodies.

Second, one of the biggest structural causes of lack of attention to NCD and mental health conditions is the time horizon for translating intervention into impact. Within the context of the policy cycle, the challenges are both political and technical. Health gains for primary and secondary prevention activities can take years to manifest, but even when there are more immediate health improvements, there has been a failure to link these to NCD and mental health programs and investments. For countries with political systems sensitive to responding to constituent demands, addressing NCDs through increased investment becomes unpalatable, even for policymakers who recognize the growing impact of NCD treatment on health budgets. New framings are needed that show the shorter-term, political benefits of addressing NCDs. Here, the public health/preventive approach comes into direct conflict with the treatment/cure approach. While the former is usually more desirable in most instances, the latter is what matters to patients and politicians here and now. A conclusion is that successful national action on NCD and mental health will often need to include a component of building healthcare capacity to treat the backlog of individuals who need care for severe NCD and mental health conditions, which can help demonstrate value to the public and make other policy changes (e.g., tobacco taxes to prevent NCDs) more palatable. These initiatives might also be opportunities to reimagine health systems to make them more people-centered and outcomes-oriented.

Third, despite the rapid growth in health data, interviewees were consistent in reporting data limitations as a major barrier to action. Modeled estimates of disease burden do not provide the information

necessary to develop, monitor, and evaluate national health programs, including their financing. While the issue of health data and surveillance is broader than this financing dialogue, the specific issue of health financing data is highly relevant. Interviewees recommended that WHO or another normative body should clearly identify what core NCD and mental health financing metrics should be collected and reported on, ideally in some sort of integrated dashboard. While national health accounts remain an important source of general health system financing data, it is likely that parallel (or intersecting) data collection systems on NCD and mental health financing specifically will be needed to hold governments and donors to account. Data on the purchase and distribution of essential NCD and mental health medicines might also be part of a disease-specific financing dashboard.

### **Section 3: Catalytic DAH to support country-level activities**

Having established the challenges and opportunities for increasing DAH for NCD and mental health programs, a consequent question is how to operationalize this funding at the country level. Most interviewees and other stakeholders hold the view that that DAH should be used for “catalytic funding” rather than an open-ended commitment to support country programs. This section explores the practicalities of catalytic funding.

The following working definition of catalytic DAH for NCD and mental health programs is proposed, which revolves around several key elements. First, such funding should be intended to accelerate or enable national actions that are already outlined in national NCD and mental health plans and strategies but are under-resourced. Second, the funding should be used to overcome known barriers to program implementation/scale-up, e.g., workforce development, capital investments, including specialized equipment, and so on. It would take the form of “short-term infusions” linked to specific implementation and policy outcomes, e.g., integration, sustainability, and full government ownership (including finance) of the health program(s) in question. It is generally agreed that financing recurrent costs (e.g., medicines) is not a good use of catalytic funding, although exceptions apply (e.g., supply chain strengthening, some market-shaping activities).

Interviewees described a range of ongoing catalytic funding projects in several settings. Examples included loan terms to incentivize increased coverage of cancer screening, providing initial investment in workforce training to integrate mental health services into primary and secondary health care, demonstrating the feasibility of task shifting NCD care to community health, and supporting the implementation of newly passed NCD prevention legislation. Our team attempted to find additional external documentation of these results of these investments, which proved significantly challenging. Improving the documentation of catalytic funding approaches and results, particularly for effective examples, and collating these examples into accessible digital platforms could facilitate knowledge sharing and increase the impact of DAH design and requests.

Additionally, the WHO and World Bank have been providing catalytic support for NCDs and mental health. A good example is the WHO’s Special Initiative on Mental Health to improve treatment access in nine



countries across the WHO regions. The initiative, which started in 2019, resulted in 52 million people newly accessing mental health services by 2023. As mentioned previously, the World Bank has been ramping up its lending primary healthcare programs, often with a strong focus on integrated care including NCDs and mental health. As a final example, several HIV donors have supported efforts to integrate NCD screening and treatment into HIV treatment programs, and the US National Institutes of Health has been a significant funder of implementation research focused on HIV-NCD integration, which has produced evidence on service delivery design that can be used by national HIV programs.

Based on our interviews and review of the literature, we propose several principles for catalytic funding programs:

1. Ideally, catalytic support should be focused on “crowding in” public finance of highly cost-effective interventions, such as those endorsed in the NCD and mental health Global Action plans of WHO and related efforts (e.g., Disease Control Priorities Project). Table 2 below provides a few examples of best-practice interventions and how catalytic funding could be used to enhance their implementation.

**Table 2 Examples of catalytic funding projects to support evidence-based interventions.**

Intervention area	Example of implementation barrier	Potential role of catalytic funding
Tobacco taxes	Industry interference in policy process	Support advocacy organizations on campaigns to counter industry lobbying in legislative process
Primary diabetes care	Poor availability and affordability of insulin	Support transition to e-procurement and strengthening of supply cold chain
Colorectal cancer treatment	Low uptake of screening outside major cities	Support pilot program to optimize community screening and establish referral systems
Mental health and psychosocial support	Lack of mental health workers in conflict settings	Support training of local health workers in humanitarian settings on psychological first aid and mental health care
Finance of health services	Limited consideration of NCDs in benefit packages	Support for priority setting exercises, including evidence reviews for cost-effective interventions

2. Countries would benefit from having a standardized approach and support for requesting catalytic funding, including tools for conducting needs assessments, support for planning grant/loan proposals, and regular communication on potential funding bodies and deadlines for proposals.
3. Funders need to acknowledge that there is not a one-size-fits-all approach to NCD and mental health. Needs and opportunities will vary according to where a country is located along the epidemiological and demographic transitions, its level of development, local institutional capacity, and other factors. Funding bodies need to ensure they have staff with requisite technical skills to fairly evaluate proposals and oversee projects.

4. Any project that runs the high risk of crowding out domestic investment should be treated with caution. If DAH has “displaced” government spending on RMNCH or infectious diseases in the past, this should be a warning sign to the donor that an NCD or mental health loan might not catalyze increased government spending on these conditions.

## 4: Additional considerations for country-level DAH

### *Exceptions to the principles in section 3*

Aside from the general approach to country-level catalytic DAH mentioned in the previous section, we reflect on three additional considerations for country projects supported by external resources.

First, a small number of countries have extremely limited resources and highly unfavorable macroeconomic and fiscal outlooks. In these countries, DAH is a major source of health financing and is focused almost exclusively on global health initiatives for unfinished agenda conditions. Their health systems have very low absorptive capacity for new disease-specific initiatives. One way forward in these situations is to reframe NCD and mental health care as part of a broader package of health budget support focusing on primary healthcare capabilities. The scope of NCD and mental health interventions that could be afforded would be low, but progress could be made on a few priority conditions to build a foundation for future expansion. DAH would emphasize building workforce competency for chronic disease management, probably building on the successes of HIV.

Second, some countries with significant conflict and humanitarian crises have fragile health systems. The considerations for DAH in these countries share similarities with the poorest countries described previously. However, some conflict settings have reasonable absorptive capacity and domestic health resources. Here, catalytic DAH could focus on building capacity, e.g., for building chronic care infrastructure to provide basic NCD and mental health care among refugees and internally displaced populations. The emphasis of catalytic funding might be different from stable countries, though; conflict settings might place higher priority on rehabilitation, trauma disorders, and filling gaps in supply of critical NCD medications (e.g., insulin for type 1 diabetes).

Third, there is increasing interest in blended finance instruments for NCDs. While blended finance—understood to mean mixing of public (or donor) funds and private capital—can work in some settings, it is not a good fit for others, nor is it appropriate for some types of health financing challenges. A working paper by the Health Finance Institute provides a framework for identifying interventions and programs that are good (and bad) targets for blended finance.<sup>4</sup> In general, the short-to-medium-term financial returns from a health intervention need to be large enough to justify the investment, and many NCD and mental health interventions do not generate large financial returns quickly (see “time horizon” in section 2). Additionally, LICs generally lack access to this sort of lending, so progress on NCD and mental health conditions in these countries will rely heavily on grants and concessional loans. Overall, in the current high-

debt, high-inflation environment, governments should be very hesitant to sign off on loans that they are not confident they will be able to repay.

### *Cross-cutting investments*

As discussed in the separate background paper on domestic finance, a range of general health finance reforms could improve financing of NCD and mental health services. The same is true of DAH. In addition to general support for primary healthcare or health systems strengthening (see above), donors may wish to consider a few high-value investments that can improve domestic financing for NCDs and mental health with spillover effects for many other health conditions.

NCD and mental health come with complex questions in terms of resource allocation. Most countries have still to upgrade or even build their analytical capacities and priority setting processes. For example, a recent review of country experiences with health benefits package design revealed a high dependence on external consultants and international literature in identifying, appraising, and costing candidate interventions for HBPs.<sup>5</sup> To make progress on prioritization and policy design of NCD and mental health interventions, many countries have to strengthen their national knowledge ecosystem. Peer-to-peer learning programs like the International Decision Support Initiative (<https://www.idsihealth.org/>) and regional hubs for training like HITAP in Thailand (<https://www.hitap.net/en/>) are sources of inspiration. Solutions adapted to low-income countries must be developed and rolled out.

Quality management of NCD and mental health calls for integrated models of care securing dimensions such as continuity of care and person-centeredness. Systems should be optimized to tackle the growing burden of multimorbidity. This is not how service delivery is currently organized in most countries. What is needed is a better understanding of how to redesign service delivery, including its financing, with complex chronic conditions in mind. While there is certainly a research agenda here, most research funding is for pilots and proof-of-concept studies that fail to be taken up by governments in large part because of inadequate financing. Donors need to step in to support the scale-up of promising models of care to the national level and disseminate these learnings within regional and global communities of practice.

Twenty-four years into the 21<sup>st</sup> century, most individuals in LICs and MICs have smartphones and easy access to the internet and cloud-based services. Yet health management information systems in many countries remain fragmented and largely paper-based. Digitalization of the entire healthcare system is an urgent priority that could greatly improve patient care (e.g., through integrated medical records systems) as well as administration (e.g., through digital financial systems, drug procurement systems, etc.) Digitalization facilitates provider payment reform and strategic purchasing, especially for case-based and per-capita payment models that require advanced administrative capacity. Special emphasis needs to be placed on building systems that can link different payment models across episodes of care (e.g., inpatient vs. primary healthcare vs. outpatient specialty care). Digital systems can also improve expenditure tracking and budget accountability to the public. Investment in digital solutions must be accompanied by

investment in data analysis capacity for the best use of them for efficient and equitable allocation of resources.

Finally, ongoing technical assistance is required for health taxes, which have not been fully implemented in most countries (see Fiscal Policy background paper). The revenues from health taxes can be used to increase general government expenditure, with downstream benefits to the health budget. In some cases, a portion of these taxes can reasonably be “soft” earmarked for disease prevention programs. But regardless of earmarking, health taxes are critical to ensuring sustainable implementation of essential NCD and mental health interventions, because inasmuch as they reduce the incidence of these conditions, they slow the growth rate in need for medical care and pressure on the public budget.

## **Section 5: Opportunities for DAH to support collective action and global and regional public goods**

While DAH plays an important role in catalyzing health programs in specific countries, it also has another important function: support for collective action. The Lancet Commission on Investing in Health, building on an earlier framework by Jamison, Frenk, and Knaul,<sup>6</sup> identified three critical functions for “international collective action” for health. These include (i) supplying global public goods, (ii) managing cross-border externalities, and (iii) exercising leadership and stewardship. The rationale for these global functions is that they address issues that go beyond individual countries, and they provide benefits to multiple countries.

The distinction between catalytic DAH and financing global functions is not discrete and clear. DAH targeted to individual countries frequently provide benefits beyond the country receiving funding. For example, a project supported by Resolve To Save Lives on optimizing implementation of the HEARTS package in one country can provide learnings for other countries in the region that have similar health systems and constraints. A World Bank-supported project on improving tobacco policy implementation in one country could include efforts to control cross-border trade. Support for air pollution control in one country helps to limit the spread of this pollution to neighboring countries. And so on. National and international projects do not have to be mutually exclusive, and funders should actively look for opportunities to fund projects that have spillover benefits.

It can be argued that a portion of DAH for NCDs and mental health should be set aside for financing of global functions, because many of the barriers that countries face in implementing NCD and mental health programs are driven by external factors. For example, several years ago, the cost of cardiovascular medicines varied widely across countries in Latin America, with some countries paying much higher prices than others, limiting access and affordability. Support to the PAHO Strategic Fund allowed for pooled procurement of these medicines, which drove down their prices by up to 99%, ensuring a more level playing field for all.<sup>7</sup> This could not have been achieved without PAHO having adequate resources. A more recent example is the Global Platform for Access to Childhood Cancer Medicines, supported by St. Jude

and other international partners. These coordinated efforts benefit many countries at the same time and require financial support.

Still, we acknowledge that collective action is difficult and can be costly. The decline of internationalism and rise of geopolitical conflict have made this even more difficult. Many donors will want to prioritize country projects with quick and visible results rather than invest in the international and regional health systems. What is needed is a systematic assessment of the priorities for collective action on NCDs and mental health that includes a justification of why these initiatives should receive priority over country projects. This effort is outside the scope of the International financing dialogue but will be worthwhile to undertake in the months leading up to the 2025 High Level Meeting.

In our consultations with interviewees and other international experts, we identified several potential opportunities for DAH to support global functions for NCDs and mental health. Table 3 provide an overview. This table merely illustrates the possibilities and does not purport to be systematic, rigorous, or to represent consensus priorities. Additionally, these examples do not include the wide range of cross-cutting investments to support health systems; the latter are being covered in an upcoming report from the Lancet Commission on Investing in Health.

**Table 4 Potential opportunities for DAH to invest in collective action on NCDs and mental health.**

Area of action	NCD opportunities	Mental health opportunities
Global public goods	<p>New product development, e.g., fixed-dose combinations for cardiovascular disease prevention</p> <p>Market-shaping to improve access to selected medicines (e.g., insulin)</p> <p>Regional disease registries (e.g., for congenital heart disease)</p> <p>New tools for costing NCD programs</p>	<p>New standardized tools to measure mental health service need and coverage across countries</p> <p>Mental health policy and implementation research (learning networks)</p> <p>Care delivery innovations for vulnerable populations with mental health conditions (e.g., refugees)</p>
Cross-border threats	<p>Regional regulations on entry of ultra-processed foods into markets</p>	<p>Technical assistance to regulate cross-border alcohol marketing, advertising and promotion</p>
Leadership and stewardship	<p>Collective action on food industry interference in national policies on sugar-sweetened beverages</p> <p>Leadership on measurement, tracking, and accountability for NCD indicators</p>	<p>Support for WHO and other organizations to develop national mental health and responses</p> <p>Support for regional champions for mental health initiatives</p>

The effectiveness of cross-border action is not reserved for the global level, and indeed multiple interviewees called out the promise of regional collective action. The advantages of regional collaboration include geographical and cultural similarities that can lower the adaptations needed for knowledge sharing; greater trust in the relevance of data from regional neighbors (as opposed to global normative documents); improved focus for donors; increased likelihood that research will be applicable across settings; as well as practical efficiencies that facilitate collaboration (e.g., time zones, lower costs to activities that bring people together).

Interviewees shared multiple examples of successful regional public goods investments:

- The Asian Development Bank has an ongoing and extensive technical assistance program in health, including NCDs, and is in the process of using this to advance a set of shared knowledge products, such as a directory of effective health responses, as well as to identify cross-country lessons in digital health transformation.
- The European Commission is working on joint actions in food marketing (e.g. supporting harmonizing labeling policies for member states, including strategies to navigate industry opposition).
- Vaccine cards that were developed for use across several Latin American countries is an example of regional data solutions.

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