DANISH RED CROSS

Finding financing: sustainable resourcing for NCDs in humanitarian settings

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Introduction

'When you look into this, non-communicable diseases are not a small humanitarian issue, yet they remain an issue that most mainstream humanitarians don't talk about'
– Peter Klansø, Danish Red Cross

This report summarises a roundtable discussion convened by the Danish Red Cross and held online on 12 June 2023. The event was the formal launch of a *Report and Recommendations for the Danish Red Cross on Potential Financing Mechanisms for the Care of NCD in Humanitarian Settings* and was an opportunity both to validate the analysis and to extend its conclusions beyond the Danish Red Cross.

Participants were posed two questions:

- From your experience, do you recognise the same problems that the report identified and have any been omitted?
- What has worked for your organisation in terms of leveraging funding, and can we identify any good examples?

Although the discussion was not formally structured around the report, many of the comments echoed and expanded upon the five challenges identified within it.

1. Complexity of the challenge

'What shone through in the research is the complexity in every dimension in humanitarian crises' – Dr Callum Pierce, ThinkWell and report author

There was strong agreement as to the complexity of addressing non-communicable diseases (NCDs) in humanitarian settings. The need for NCD financing varies greatly between different settings, which makes it challenging to define for donors what needs financing, where, and for whom.

NCDs are not something that can be treated as a one-off: a continuum of care is required, from prevention through to treatment and palliative care, requiring ongoing and potentially lifelong support. This can feel overwhelming to potential funders.

Humanitarian crises themselves are also on a continuum: from disaster preparedness, through the acute phase and into protracted crises and longer-term rebuilding. In the acute phase, urgent treatment such as insulin provision will be at the fore – and people living with NCDs themselves may be forced to prioritise issues seen as being more urgent. In longer-term settings, and among refugees, prevention and screening become greater priorities, including as the emergency context shifts to preparedness and potentially to become a development context. A tiered approach, starting with a focus in primary care, is required. All these may require different funding mechanisms.

NCDs do not just need to be funded in the country where the crisis started, but also in countries hosting refugees – and here the health systems may be struggling to provide care even for their own citizens. Refugees may not have the same rights as the host population and not be included in financing mechanisms such as national insurance schemes.

Which NCDs?

There are other existing mechanisms to address mental health and psychosocial support (MHPSS) in humanitarian settings and so mental health was not included in the report, despite the significant co-morbidities and co-benefits with other NCDs. However, participants felt that mental health should be part of this funding conversation. Similarly, NCDs that are more common in lower-income settings, such as rheumatic heart disease, should not be sidelined – as the Lancet Commission on Reframing NCDs and Injuries for the Poorest Billion has highlighted.

There are also different organisational contexts: humanitarian actors have different ways of raising and spending financing. It is important to find a common language and establish common aims that help to cut

through the complexity and make NCDs understandable for donors. An effective way to do this is to embed NCDs in the primary care system, which can deal with much of the initial burden, prior to referral to more specialised care.

One question raised was whether different NCDs should be addressed individually rather than collectively, particularly as 'non-communicable diseases' is not necessarily a well-understood term. Interventions can vary significantly between, for example, diabetes, cancer, mental health or NCDs that are more common in the lowest-income settings such as rheumatic heart disease. The Global Fund has been successful in addressing communicable diseases individually, but there are more co-morbidities among NCDs so a different approach may be needed.

2. Shortfall in existing financing

'We know what needs to be done, we know how to do it efficiently,
and we know who can do it. And yet we are still struggling with who will pay for it'
– Dr Rachel Nugent, RTI International

The discussion echoed the report in making the case that the financing for NCD care is both dramatically insufficient and is also tiny in comparison with the actual burden of diseases in humanitarian settings. Acute and communicable diseases tend to receive the vast majority of available emergency funding and, although NCDs are included in some grants, funding is nowhere near enough. It was also pointed out that some of the financing mechanisms in the report – such as performance-based financing – may simply be a new channel, rather than providing the additional resource that is so urgently needed.

This shortfall in financing for NCDs is not unique to humanitarian settings: it is true across the board for NCDs. It is essential that governments' anticipatory investment (disaster preparedness) properly takes into account the burden of NCDs on its population. The Health4Life fund for NCDs was established to raise $250 million from donors, on which governments could call to use on catalytic NCD programmes in-country – but even this has not been successful in raising new resources.

3. Inadequate evidence

'The problem is that you are going to someone who doesn't know much about NCDs
and humanitarian settings and telling them that there is insufficient financing –
but then that we don't know what the priorities are!' – Professor Pablo Perel, LSHTM

One of the main reasons proposed by the report for the reticence of donors to financing NCD prevention and care – with which participants at the meeting strongly agreed – is the lack of evidence to inform prioritisation of resources: even where funding is available, where will it have the most impact? Often, the true prevalence of NCDs is not known, making it a real challenge, for example, accurately to cost out NCD care or to show the benefits of a focus on primary care – even prior to a humanitarian crisis. Supporting national-level data-gathering and health information systems can provide valuable baseline data and a better indication of need and, therefore, of what care is required.

Comparing the cost of a package of care that includes NCDs with the cost of not providing these services can help to make the case for action. However, a simple focus on 'return on investment' is unlikely to lead to prioritising the most vulnerable populations, including in humanitarian settings. Other economic studies, such as cost-effectiveness and looking at co-benefits with other sectors, may be more catalysing of donor action for such populations. Starting with an assessment of equity and effectiveness of current systems may reveal what change would make the system most effective for patient and population impact.

There is also a lack of independent evidence on how well different financing mechanisms (including some noted in the report) work in practice – and they may not have been used in humanitarian settings.

4. Key role of primary health care

'I *would argue that in the case of NCDs, we do need additional financing or*
specific financing for NCDs, to make sure that they are not excluded, with
specific funds earmarked for increasing capacity to integrate NCD care, primarily
at primary care level' – Dr Mike Woodman, UNHCR

The report notes that the primary health care (PHC) system is essential in delivering affordable NCD care – but, even before a crisis, there is a long way to go before NCDs are fully embedded within many countries'

universal health coverage (UHC) packages. PHC is central because so much of the NCD continuum – from prevention, through screening (for common conditions) and diagnosis, counselling and basic care including palliative care – can take place at community and primary care level, as well as better referral (where possible) to secondary and tertiary care in hospital. PHC is delivered within local communities, saving the patients the time and expense of travel and the higher costs of being treated in a hospital – and services can be co-located (including with infectious disease and with mental health care), meaning that treatment may be more holistic and patient-centred.

Task-shifting and task-sharing can help to ensure better access to PHC. Online and cascade training (such as that provided by the PCI Academy) can benefit health workers in humanitarian settings. Community health workers can be key to strengthening health systems, providing on-the-spot care in their communities, by whom they are trusted.

In some cases, 'reverse referral' has taken place in refugee settings, where the specialists visit the camp at specific times, enabling people living with NCDs to receive specialist review. Some participants also noted, however, that some NCDs are too complex to be treated in primary care settings.

Although robust PHC is a vital part of crisis-resilience, there may be hesitancy among donors in setting up primary health systems because of the length of time required for funding to continue and a lack of understanding of what exactly is needed, including professional and political resistance to decentralising care. It is also important not to establish parallel systems, as this is likely to undermine existing national systems, leaving populations vulnerable when funding ends.

5. Market failure: expensive medicines and diagnostics

One way to narrow the disparity between funding and burden of NCDs would be to lower the cost of NCD pharmaceuticals, diagnostics, and services, which – as the report notes – are more expensive than they need to be. The expense of NCD care impacts both on government spending on health (for example, what can be provided through basic UHC packages) but also on individuals and their families: even where NCD medicines are theoretically accessible to patients, the out-of-pocket cost can be catastrophic or take them wholly out of reach of the most vulnerable. Patients may also be hesitant to move to generic drugs, rather than the more expensive medication that they have been used to prior to a crisis.

One way to reduce costs is to pool procurement, with governments working together to combine demand and to ensure reduced prices from the suppliers: the Africa CDC includes it in its five-year Strategy on NCDs (2022–26) and there may be learning here from other disease areas. Pooled procurement can also negotiate lower prices for bundles of NCD services – such as insulin strips and glucometers – which can vary significantly in price between different countries. Ensuring that medicines can be produced locally may also help to reduce costs.

Funding mechanisms

Participants felt that there is an important need to map and understand existing funding mechanisms – something which the report begins to do in its annex summarising six different mechanisms. The discussion also noted possible other potential future avenues, such as social impact bonds or trust funds in the regional development banks (which can leverage funding from multiple sources). For example, the Transform Health Fund (a joint venture between the Health Finance Coalition and AfricInvest), which invests in local supply chains, care delivery and telehealth solutions, could point a way forward.

There are also other ways of working, such as the pooling of resources that occurred through the Africa CDC's Covid-19 Fund. Bilateral funding is also a possibility that was not mentioned in the report. Caution was urged around public-private partnerships, which must prioritise the most vulnerable.

Ways forward

Participants welcomed the report and felt that it was reflective of their experience. Two clear ways forward were suggested.

First**, collaboration and coordination** are essential. We need to build 'connective tissue': the social and professional networks that create trust and help to ensure sustainability of initiatives. Collaboration will need to go beyond the healthcare sector per se, looking at the social determinants of health and at interventions beyond health (such as tax policy).

One way forward could be to establish a donor caucus that meets regularly on a broad range of priorities: too often, programmes are siloed because the donors themselves are siloed, rather than being complementary and synergistic, which leads to a waste of already scarce resources. It was also suggested that the efforts of the Danish Red Cross – with other partners including Danida and Novo Nordisk – could act as an exemplar for other countries in terms of national coordination.

Secondly, good collaboration can facilitate better **advocacy**, both nationally and globally, ensuring a common approach to capturing learning and sharing best practice. To date, NCDs have not received anything like the level of advocacy of HIV or pandemic preparedness – but taking action on such a major health issue should be part of donors' global moral responsibility. Presenting NCDs in humanitarian settings as an integral part of UHC (particularly this year, in the light of the UN High-level Meeting on UHC) is important but is not sufficient to make the case to all audiences. Successful advocacy requires developing a common language with donors and policymakers: for finance ministers, for example, frame this as an investment in human capital and the country's future.

Advocacy is also likely to prove easier if those seeking funding can identify a crystal-clear focus for where the resources will be spent, what they will do and who they will help. There are potentially many points of entry to this conversation with funders and, in a crowded global-health space with dwindling resource, any such call needs to be clearly targeted.

Finally, the **involvement of people living with NCDs** themselves is essential in identifying the real needs of populations in humanitarian crises – and hearing from lived experience can be of vital importance in advocacy efforts.

Participants

The Danish Red Cross particularly thanks Dr Callum Pierce (ThinkWell) for writing and presenting the report, the two respondents Dr Lilian Kiapi (International Rescue Committee) and Dr Rachel Nugent (RTI International), and Katy Cooper (independent consultant) for moderating the roundtable and preparing this summary.

Thank you, too, to all those who attended, drawn from the Africa CDC, the Clinton Health Access Initiative, the Danish Ministry of Foreign Affairs, the Danish Red Cross, the Eastern Mediterranean NCD Alliance, Harvard Humanitarian Initiative, the Harvard Medical School, the Helmsley Trust, IADA, the International Committee of the Red Cross, the International Federation of the Red Cross, the International Rescue Committee, the London School of Hygiene and Tropical Medicine, Médecins Sans Frontières, MSF Denmark, the NCD Alliance, Novo Nordisk, the Novo Nordisk Foundation, Primary Care International, Roche, RTI International, Santé Diabète, ThinkWell, UNHCR, UNRWA, the World Bank and the World Diabetes Foundation.

References

Additional reading was provided by participants during the roundtable:

R. Baltussen et al., 'Decision-making processes for essential packages of health services: experience from six countries' (2023) BMJ *Global Health* 8(Suppl 1): e010704 https://doi.org/10.1136/bmjgh-2022-010704

International Alliance for Diabetes Action, *Report of the 3rd Annual Symposium on Diabetes in Humanitarian Crises* (2022) https://uploads-ssl.webflow.com/5f6e4a0c801c46ad247a517d/63be4b17f1dcf7bf835fe106_2022%20Krakow%20Symposium%20Meeting%20Report.pdf

IRC, *Package of Essential Non-Communicable Diseases Interventions for Humanitarian Settings (PEN-H)* (2020) https://www.rescue.org/report/package-essential-non-communicable-diseases-interventions-humanitarian-settings-pen-h

LSHTM NCDs in Humanitarian Setting hub https://www.lshtm.ac.uk/research/centres-projects-groups/humanitarian-ncd#welcome

J. Manne-Goehler et al., 'Health system performance for people with diabetes in 28 low- and middle-income countries: a cross-sectional study of nationally representative survey' (2019) *PLoS Med* 16(3): e1002751 https://doi.org/10.1371/journal.pmed.1002751