The George Institute for Global Health

Response to the public consultation on the preliminary draft report of the WHO Independent High-level Commission on Non-Communicable Diseases

16 May 2018 - The George Institute for Global Health welcomes this opportunity to respond to the public consultation on the preliminary draft report of the WHO High-Level Commission on Non-Communicable Diseases (NCDs). We applaud the Commission's efforts to inject greater urgency into country actions to reduce premature mortality from NCDs, and wholeheartedly endorse its aim to identify bold recommendations that are 'transformative, actionable and innovative'. However, we feel there are a number of areas in which the report could be strengthened further.

First, we suggest that if the High-Level Commission's report is to have real impact, there must be a more explicit recognition throughout that **most NCDs are caused first and foremost by unhealthy environments** which engender obesity, physical inactivity and the harmful use of tobacco and alcohol. Solutions must therefore focus primarily on addressing these environments.

Related to this is the need for a more specific exposition of the commercial underpinnings for most NCDs in most settings, whether these are determined by tobacco, diet, alcohol, lack of access to care or other factors. While business-driven approaches based on voluntary, public-private partnerships are attractive and are likely to be part of the solution, **a wide-ranging, enforceable, health-in-all-policies approach** implemented by bold governments acting in the interests of the people is the only measure that will have the magnitude of impact rightly sought by the High-Level Commission.

We urge the Commission to emphasise throughout the report the urgent need for greater recognition that NCDs impose a particular burden on women's health, and of the **intersecting social and gender inequalities that determine health inequity**. We would also ask that the report recognises the need for more research to drive evidence-based solutions that can help close unacceptable health disparities between genders and different social groups.

The report mentions that we have evidence-based solutions to address NCDs, but these are not being implemented at the national level. In response, we would like to highlight the urgent need to identify **effective, evidence-based implementation strategies**. We urge governments and NGOs responsible for implementation to engage with broader expertise, including academic groups with an understanding of implementation science, who can provide technical advice and assistance. We call for the report to recommend that researchers, implementers, policymakers and those funding interventions should work together from the outset to identify innovative, scalable approaches.[i]

The Commission also recognises that national investments in tackling NCDs remain inadequate, and not enough funds are being mobilised internationally. We suggest that in addition to a need for greater overall health investment in absolute terms, there is a need to strengthen **transparent, evidence-based processes for setting health priorities**. Evidence shows that demonstrating the cost-effectiveness of different prevention and treatment programmes – for example, through health technology assessments – leads to greater investment in those programmes targeting NCDs.[ii]

In addition to these general points, we would like to offer some comments on specific content within the preliminary report:

- **Paragraph 13** highlights that 'failure to implement proven interventions is rapidly increasing health care costs'. In addition to the supply-side problem flagged here, there is a demand-side constraint on the uptake of proven interventions: the **financial barriers to adherence**. Many interventions are long-term and repetitive (e.g. anti-hypertensive drugs), and in these cases, out-of-pocket costs are a major contributor to treatment abandonment. Addressing this constraint requires the targeting of subsidies to such proven, cost-effective interventions, through either public funding or social insurance programs.[iii]

- **Paragraph 15** (among others) rightly highlights the enormous burden of mental health conditions on societies. However, nowhere does the draft report mention **suicide**, despite the fact that this is one of the leading causes of death among adolescents. Where the report calls for action to address mental health, we suggest it should stress the need for national-level interventions specifically aimed at reducing adolescent suicide rates.

- **Paragraph 24** mentions that other SDGs are relevant to the NCD agenda, including SDGs 11, 12, 16 and 17. We urge the Commission to add **SDG 5: Achieve gender equality and empower all women and girls**. Many women are affected by persistent social, gender and economic inequalities and health inequities that increase their risk of developing and dying from NCDs; poor women, especially those living in Low- and Middle-Income Countries, are the least likely to have access to affordable diagnosis, management and treatment services.[iv] We call for the report to emphasise differences in the way women and men develop, experience and are treated for NCDs; for example, several risk factors for cardiovascular disease are female-specific, such as preeclampsia during pregnancy.[v]

- Also related to **paragraph 24**, we would question whether adequate accountability measures exist for these other SDGs, and suggest that **non-health-specific goals should be linked to improvements in health-related risk factors**. Given the major role played by the physical and social environment on NCD risk, action taken in the health sector alone will have a limited impact on the population incidence of NCDs.

- **Paragraph 27** mentions that many countries need technical support to address NCD challenges. We suggest that developing capacity to undertake **health technology assessments** (HTAs) is critical in ensuring that benefit packages and public subsidies are directed toward interventions that yield the maximum population health benefit (e.g. HITAP in Thailand and MTAB in India), particularly in highly resource-constrained environments. However, establishing capacity to undertake an HTA is itself costly. As many of the tasks of HTAs and the evidence relevant to individual decisions are common across settings, we suggest there should be consolidation of HTA activities at a regional or global level.

- **Paragraph 30** mentions a number of obstacles to the implementation of proven interventions for NCDs. We suggest that institutionalising an **evidence-based process for health-sector investment** can be a means of overcoming political barriers. Making a legislative commitment to follow an

independent process limits the ability of policymakers to exercise discretion on a case-by-case basis, and therefore short-circuits pressures potentially exerted by commercial and other interests. For example, in Australia, the Minister for Health is restricted by law from introducing new medicines onto the Pharmaceutical Benefit Scheme without a health technology assessment conducted through the Pharmaceutical Benefits Advisory Committee.

- **Paragraph 32** recommends that all activities be framed within existing principles, including human rights and equity-based approaches. We urge the Commission to stress the need for countries to take **gender inequities** into account in all NCD programmes. We also urge the Commission to call on governments to adequately **address the social inequalities that determine health inequity for indigenous peoples** such as the Aboriginal and Torres Strait Islander peoples in Australia, engaging meaningfully with communities and enabling them to lead decisions affecting their health and wellbeing. We also highlight the need for more research to drive evidence-based solutions that can help close unacceptable health disparities between people of different social groups and ethnicities in contexts worldwide.

- **RECOMMENDATION 1:** The report states that prioritisation is the key to achieving scale-up. We would endorse **a prioritisation approach that is strongly focused on primary care**, with the main focus on integration into horizontal platforms (primary health care system strengthening), rather than on introducing new, vertical NCD programmes into primary health care. Thoughtful and cautious integration with existing vertical programs should be considered - for example, integration with HIV programmes may be reasonable given the life-long care required - but integration with other programmes with short-term follow-up, such as tuberculosis, is likely to be problematic unless it is linked to a strong primary care system. We urge the Commission to recognise **the growing epidemic of multimorbidity** in both high- and low-resource contexts, and to emphasise the need for health care providers to focus on **patients** - not isolated diseases.

- **RECOMMENDATION 1 a)**: The Commission recommends that countries prioritise a few of the cost-effective interventions endorsed by the World Health Assembly. We suggest WHO could provide an **update on the 'best buys', focusing specifically on NCDs, health technologies and generic drugs,** and providing guidance on which options offer the lowest costs and clinically proven benefits. Consideration of **gender differences in the way NCDs are experienced and treated** is a key component in ensuring appropriate, cost-effective care. Consideration should also be made of the **financial barriers to adherence** of some of these interventions, as highlighted in relation to paragraph 13 (above).

- **RECOMMENDATION 1 a) 2)**: As a WHO Collaborating Centre on Population Salt Reduction, we strongly support the recommendation that country priorities should include reducing sodium. We suggest that as a first step, countries should **identify the main sources of salt** and then establish a strategy to target these sources, in line with recent WHO EURO guidelines.[vi]

- **RECOMMENDATION 1 a) 3)**: The report recommends that every patient with hypertension should be treated. Given that one third or more of the adult population has hypertension (depending on diagnostic criteria), we suggest that this would be an inefficient use of scarce resources, as the majority of the hypertensive population is at low risk and drug treatment would not be cost

effective. Research suggests that from a population perspective and where resources are scarce, it is better to focus treatment on those with high blood pressure and who are at high risk of cardiovascular disease; this is the approach recommended in guidelines worldwide, including WHO's Global Hearts initiative. In this group, treatment is highly cost-effective. We urge the Commission to recommend that governments adopt **risk-based strategies on treating hypertension**, based on the country-specific risk charts produced by WHO, and consider the implementation of technology-assisted, risk-based approaches that can be delivered by community healthcare workers.

- **RECOMMENDATION 2 b) 1)**: We welcome the report's recommendation that countries should work towards promoting a healthier environment, and urge the Commission to further emphasise the need for different government departments to work together to manage NCD risk factors. In addition to promoting the healthier design of buildings and roads, we suggest the report flags the need for **healthier transport options including cycle routes and pedestrian walkways**, and highlights the links with SDG 11.2 on sustainable transport and improving road safety. We suggest the report recognises the impact of motorisation on physical activity, obesity and as a result NCDs, and stresses that better access to public and active transport increases physical activity at a population level.

- **Paragraph 39** recommends that governments should employ their regulatory and legislative powers to protect their populations when necessary. We strongly support this recommendation, and suggest that the need for **strong government regulation around sugar, fast foods, tobacco and alcohol** be emphasised further in the report.

- **Paragraph 40** of the report highlights the potential role of socially responsible investing. We believe that **social impact investment represents a promising means of bringing new resources into health** and offsetting the risks traditionally incurred by the public sector in investing in disease-prevention programmes. However, it is critical that such investment is underwritten by a Ministry of Health, donor or other body that is willing to pay out for demonstrable outcomes; for example, population risk reduction, other health gains or cost savings. The promotion of social impact investment can help to shift the mind-set of funders from the traditional model of payment for activities to payment for outcomes instead.

- **RECOMMENDATION 2**: We support the exploration of public-private partnerships (PPP) for an effective scale-up of low-cost care, and suggest there should be meaningful consideration of whether Universal Health Coverage can be achieved without this. We suggest that countries could establish a **common reporting framework to measure and publish the impact of PPPs**. This could eventually lead to an index-style measure such as the FTSE 100, which could improve transparency and increase awareness of the potential impact of PPPs.

- **RECOMMENDATION 2 b)**: We urge the Commission to strengthen the language used here, to suggest that governments do not just 'explore' regulatory and legislative solutions to minimise health-harming products, but prioritise those solutions. The report should recognise the links between this recommendation and the previous Recommendation 1 a) 2): Countries should prioritise reducing sodium and eliminating artificial trans-fat. Key to most effective salt-reduction

strategies to date has been the development of target levels for salt in different categories of food. There is clear scope for WHO to work with its Collaborating Centres to facilitate this target-setting process by **establishing a set of global targets for salt levels** which can be adopted or incorporated into legislation at the national level.

- **Paragraph 44** recognises the contribution made by human capital to the wealth of a country. We would add that **any measure of human capital must factor in unpaid work**, including child rearing, housework and caring for the elderly and the sick.

- **RECOMMENDATION 3**: We suggest the recommendation to increase funding for action against NCDs should explore broader, **more innovative financing mechanisms**, which might involve PPPs.

- **RECOMMENDATION 3 a) 1)**: We strongly support the recommendation that national governments should increase resources going towards NCDs. However, we believe this could be more effectively framed as a recommendation that national budgets for health should be increased with an emphasis on **investing new and existing resources into programmes that are cost-effective**. The current evidence indicates that this will lead to greater investment in NCDs.

- **RECOMMENDATION 3 a) 2)**: We support the recommendation that national governments should increase taxes on tobacco and alcohol. We urge the Commission to add that **governments should also increase taxes on processed foods high in salt, fat or sugar**.

- **Paragraph 47** recommends the development of a 'Countdown 2030 for NCDs'. We suggest that this would be more effective if it **considers gender differences in the way women and men access health care**; for example, women access health services throughout pregnancy, providing an excellent opportunity to integrate risk-factor management for NCDs into a broader health agenda.

- **RECOMMENDATION 4:** We support the call for stronger accountability for action on NCDs, and urge that accountability mechanisms include a requirement for **all health care providers to generate sex-disaggregated data that inform gender analyses**. These analyses should be used to identify evidence-based strategies to ensure more equitable care, particularly for women and girls in low-income countries, who are often most vulnerable and hardest to reach.

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[i] As, for example, in the current scale up call under the banner of the Global Alliance for Chronic Diseases – see https://www.gacd.org/funding/calls-for-proposals/gacd-scale-up-call

[ii] Bertram et al., Investing in Non-Communicable Diseases: An estimation of the return on investment for prevention and treatment services, *The Lancet* 4 April 2018 https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30665-2/supplemental

[iii] Jan et al in the *Lancet Taskforce on the Economics of NCDs* series highlights why providing coverage for such long-term, predictable costs associated with chronic disease can lead to problems of adverse selection in voluntary insurance programmes. This is akin to the problem in commercial insurance markets of providing coverage for 'pre-existing conditions'. Compulsory prepayment systems based on taxation or social insurance contributions is one clear way to address this problem.

[iv] http://www.who.int/bulletin/volumes/91/9/13-117622.pdf

[v] https://www.womenandncds.org/content/dam/microsites/taskforce-on-women-and-non-communicable-diseases-ncds/resources/in-brief-women-and-cardiovascular-disease.pdf

[vi] See http://www.euro.who.int/en/health-topics/disease-prevention/nutrition/publications/2018/using-dietary-intake-modelling-to-achieve-population-salt-reduction-a-guide-to-developing-a-country-specific-salt-reduction-model-2018

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