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Understanding health spending for SDG 3

In The Lancet, the Global Burden of Disease Health Financing Collaborator Network present new estimates of historical global health spending and future estimates for 2030 and 2050 using ensemble modelling techniques. Additionally, their contribution breaks down health spending for Sustainable Development Goal (SDG) 3, healthy lives and wellbeing, and for pandemic preparedness. They note that since the development and implementation of the SDG agenda in 2015, health spending has increased. Spending on SDG3 has also increased, but not in all countries, and progress towards meeting targets has been mixed.

Tracking spending for SDG3 is relevant to policy makers and complements previous efforts by Stenberg and colleagues who estimated the additional funds needed to reach SDG3 in low-income and lower-middle-income countries. Furthermore, the long-term projections of health spending to 2030 and 2050 provided here contribute a useful overview of global and regional developments in health expenditure. We believe that more can be done to increase policy relevance and contextual understanding of data such as those presented—eg, by going into more depth regarding trends in current and future global health spending. An improved understanding of these trends is valuable for policy making and useful for stakeholder groups engaged in following up governments’ commitment to health.

Another takeaway from the present Article is that increased funding is needed to achieve SDG3, in particular in low-income countries, and the authors argue that interest in domestic resource mobilisation has been renewed as a key strategy for generating resources for SDG3. We would go even further and argue that current trends show that improved domestic resource mobilisation will be the only way for these countries to mobilise the resources needed for SDG3. The present Article and previous publications from the Global Burden of Disease Health Financing Collaborator Network clearly indicate the diminishing importance of development assistance for health (DAH) for financing services at the country level, even for disease areas commonly perceived as highly dependent on DAH. The projections to 2030 indicate that DAH will continue to be important in some low-income countries at the end of the SDG period, but this finding is more a consequence of the lack of growth in domestic spending than an effect of increasing DAH.

The Article also raises questions about the future role of DAH, suggesting that a need exists to shift attention to using DAH for funding “so-called global public goods” for health and collective ability to respond to global health threats. This suggestion has been emphasised before and we agree that a shift in funding is needed; and this has become increasingly clear in light of the current coronavirus disease 2019 pandemic. Furthermore, global commitment to achieving universal health coverage requires a gradual move from siloed funding for specific diseases, earmarking of funds, and limitations on what DAH can be spent on (eg, many development partners are still reluctant to finance salaries). Instead DAH, like governments’ own health spending, should be allocated to a broad set of interventions addressing the most common health needs of the population. Resource allocation would typically be defined in a country’s essential health-care package, and we argue that such country-owned packages should be the centrepiece to determine how resources, including DAH, should be allocated. While countries’ efforts towards universal health coverage are increasingly formalised, future analyses from the Global Burden of Disease Health Financing Collaborator Network could hopefully also track progress towards this goal.

In the present Article, the authors also present funding estimates for specifically relevant areas for SDG3—ie, HIV/AIDS, tuberculosis, malaria, and universal health coverage. Although these estimates might be useful for...
There is a cost to being Black in the UK: a tax on the colour of a person’s skin. It is the price paid for other people’s perceptions of what skin colour means about one’s abilities, behaviour, or worth. Black people pay in many ways, including poorer health, higher rates of litigation against them, and slower career advancement. These adverse impacts are well described,1–3 strategies to address them have been far too slow in coming.3 Black people also pay a minority tax—ie, the burden of additional responsibilities placed on them by organisations in the name of diversity.4

Since the police killing of George Floyd in the USA and the subsequent anti-racism protests in many countries, UK higher education institutions have hastily declared their support for the Black Lives Matter movement. Welcome as these declarations are, what is needed is concrete action that actively includes and responds to the voices of minorities themselves. Therein lies a major problem. How many institutions have effective mechanisms to capture and understand what Black and minoritised academics have to say about their experiences?

The heavy burden of documentary evidence, implicit distrust of complainants’ accounts, and inability to maintain confidentiality mean that current equality and diversity procedures may deal poorly with racism as it is often experienced.1,4 For example, early in my career I encountered a senior colleague who, repeatedly, inaccurately, and always in group settings, referred to my hair as “rastas”. This made me feel uncomfortable. How and to whom does a junior staff member in a similar situation safely articulate their discomfort? How do we capture the effect of such behaviour on the seriousness of decision making and to whom does a junior staff member in a similar situation safely articulate their discomfort? How do we capture the effect of such behaviour on the seriousness of decision making and to whom does a junior staff member in a similar situation safely articulate their discomfort?

Tools exist, such as the Perceived Racism Scale5 or Inventory of Microaggressions Against Black Individuals,6 that can measure racism and unconscious bias within institutions, but who is going to pay for the effort required to make change meaningful? Despite their declarations of solidarity, will universities, still

Equity in excellence or just another tax on Black skin?