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In Reply Ongoing development of robust, sustainable, and equitable health systems will require investment of domestic resources, particularly government resources. Nonetheless, recent forecasts of gross domestic product, government spending, and government health spending suggest that for the poorest countries in the world, funding the health system exclusively with domestic resources may remain challenging.[1] While development assistance is one avenue to generate more resources for health,[2] Mr Jumbam and colleagues are right to point out that there is evidence that DAH has in the past systematically depressed domestic government spending on health, and this substitution should remain a concern to those hoping to catalyze health gains.[3,4]

While there is evidence that donor funding can "crowd out" domestic government funding, and economic theory explains that this substitution may be "rational," important questions remain. First and foremost, it is critical to know if and how in the future DAH and government health spending can work together as complements rather than substitutes. Potential methods to achieve donor and government funding complementarity would be to provide development assistance so that it is dependent on and coordinated with "counterpart financing," as is Global Fund for AIDS support,[5] or so that it targets global public goods that have transnational effects but are generally outside of the purview of any particular country. In addition, pay-for-performance schemes and arrangements like those modeled by the Global Financing Facility aim to ensure complementarity and improve the quality of services delivered.

In addition, it is important to further test the assertion that DAH is, as it is provided at the moment, still crowding out government funding to the health sector. Previous research on this topic relied on data that extended through 2006 and 2010, and global health financing continues to evolve.[3,4] If substitution persists, it is also important to measure where government health funds are being displaced. Reallocation of government funds to allied sectors such as education or poverty reduction programs may still lead to health gains, albeit through a different mechanism.

Moving forward, it is important to reflect on the fact the current funding for health in many low-income countries is not enough, and that funding in many lower-middle-income countries relies too much on out-of-pocket spending, such that resources are not equitably disbursed and major health events can lead to impoverishment. Raising more resources for health in these countries, to be paid in advance, pooled across individuals, and sustainable, is essential. Donors can play a role in supporting these systems, but government commitment, resources, and leadership are of the utmost importance.

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Reasons for Increases in Complications of Diabetes

To the Editor Dr Gregg and colleagues[1] identified a resurgence in diabetes complications in the United States beginning in 2010 and analyzed potential underlying contributors and policy implications. However, there may be another underlying mediator of the effect that the authors did not consider.

There has been a decline in the incidence of diabetes that began in approximately 2009.[2,3] With changes in the diagnostic criteria and emphasis on screening for diabetes over the last 2 decades, US clinicians likely diagnosed a large number of previously unrecognized cases in the earlier part of this century. This increased identification may have artifactually reduced the rate of complications because of a bolus of relatively early cases of diabetes. Now that diagnostic behaviors are more stable, the proportion of recently diagnosed patients among the population with diabetes is less than a decade ago, leading to the appearance of a phenotype of more complications.

A related phenomenon is that the duration of diabetes at a given age may be driving the increase in complications, which is most evident in the emergence of type 2 diabetes in youth and increasing rates of diabetes in younger adults. Likely driven by the obesity epidemic, people are developing diabetes earlier, and thus someone aged 50 years with diabetes today may have had the disease for 10 years, whereas a decade ago, they may have developed the disease later. Neither of these possibilities diminish the urgency with which these trends should be further examined and addressed.

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In Reply We agree with Dr Buse's potential explanation of our findings[1] that the changing characteristics of the underlying population could be a key factor, particularly affected by a shift in the duration of disease. Data from the US National Diabetes Surveillance System indicate that the median duration of disease increased by 2 years between 2010 and 2016 (from a median of 7.4 years to 9.4 years).[2] The shifting distribution of duration of disease may also have multiple causes.

In addition to those noted by Buse (screening, testing, and diagnostic thresholds), declining mortality rates in both middle and older age groups are increasing the proportion of persons with long-standing diabetes.[3] However, the increase in median duration of disease was modest in adults aged 18 to 44 years (0.6 years) compared with those aged 45 to 64 years (1.7 years) and those aged 65 to 74 years (2.5 years).[2]

Thus, it seems unlikely that the changing duration of disease explains the difference in trends between young adults and older adults, and we agree with Buse that better understanding of the heterogeneity of obesity and young-onset diabetes is crucial because of the implications for the future burden of diabetes complications. Unfortunately, the degree to which each of these factors affects diabetes complication rates has not been properly quantified, and existing national data on hospitalizations lack the information to do so. As we noted in our Viewpoint, the effect of health care access, delivery, and preventive care also remain inadequately quantified despite being potentially powerful levers for positive change.

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Challenges of Dual-Physician Couples

To the Editor We agree with Drs Ferrante and Mody that dual-physician households face professional and personal challenges.[1] However, we are chagrined by their view that dual-physician couples are unique or in greater need of "21st-century strategies" for dealing with life challenges than other professional women. All working women, whether single, married, or in a committed relationship, and whether they do or do not have children, confront the difficulties of achieving economic stability and work-life balance. Dual-physician couples are not alone in struggling with student loan debt, weighing child-bearing decisions with professional advancement, or trying to fulfill personal and professional goals despite inadequate support or guidance.

The authors' proposals to focus additional funding and systems only on dual-physician couples could potentially disadvantage other populations that are already underrepresented or underserved in professional medicine. For example, single female and homosexual physicians who want a family while continuing to pursue career goals would also benefit from the authors' strategies.

The early career process for any recent graduate of a post-baccalaureate education, profession, or training program, is fraught with the need to make personal and professional decisions. Unlike other recently graduated professional couples who must negotiate individual career and relocation opportunities, dual-physician couples have the option of prioritizing partner geographic proximity or training site desirability. The National Resident Matching Program, which does not exist in similar demanding professions, already successfully facilitates couples' personal and professional alignment. Because the program is voluntary, couples may decline enrolling if, for instance, they choose to prioritize maximization of individual training site assignment. Such a choice might include consideration by both partners to become a commuter couple, not dissimilar to many other professional couples.

Changing career demographics for men and women will likely lead to the emergence of a critical mass of effective role models who have successfully navigated the challenges of balancing personal and professional aspirations. Until this critical mass is established, we propose expansion of secondary education career counseling to include information regarding inherent benefits and challenges of career and lifestyle choices and pathways to balance these possibilities. Conversations during adolescence would foster early engagement of young adults in open communication and necessary forethought about professional and personal goals with the