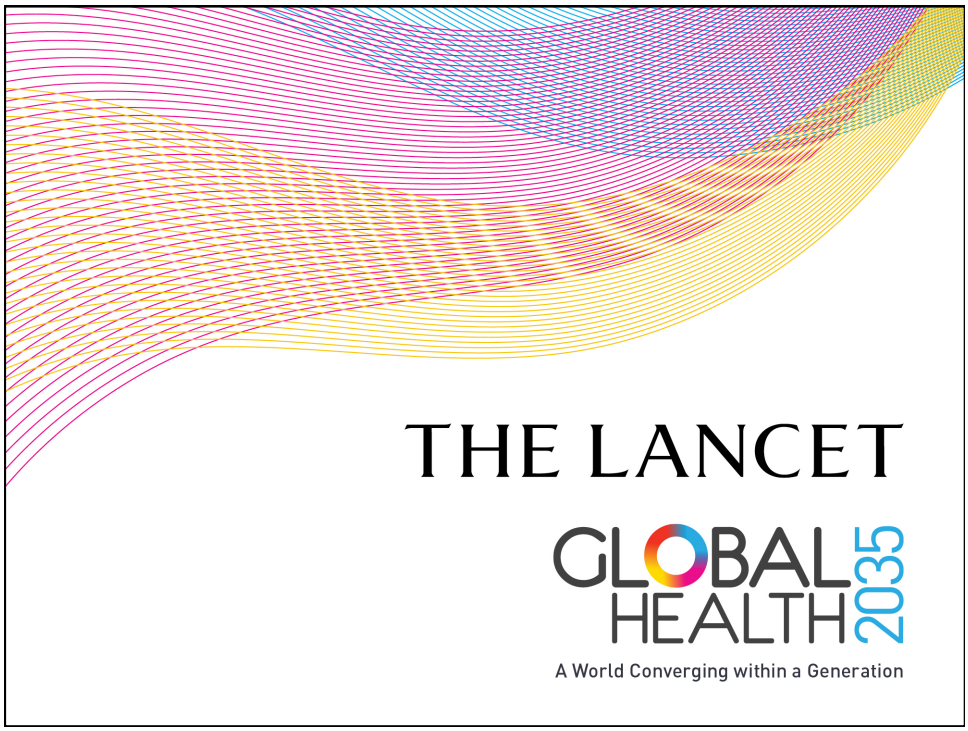


Global Health 2035: WDR 1993 @20 Years

The World Bank's World Development Report 1993

- Evidence-based health expenditures are an investment not only in health, but in economic prosperity
- Additional resources should be spent on cost-effective interventions to address high-burden diseases

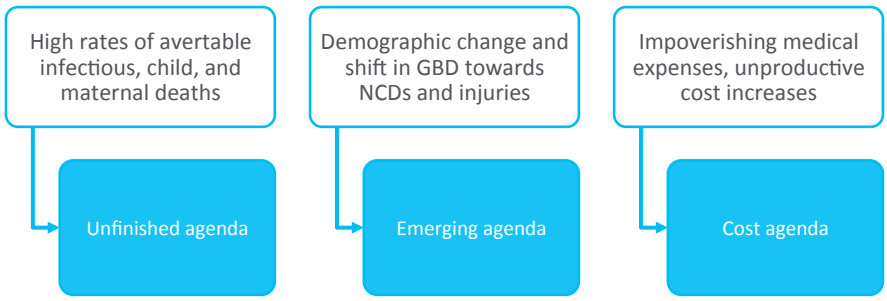
***The Lancet* Commission on Investing in Health**

- Re-examines the case for investing in health
- Proposes a health investment framework for low- and middle-income countries
- Provides a roadmap to achieving gains in global health through a 'grand convergence'

Global health 2035: a world converging within a generation

Dean T Jamison, Lawrence H Summers*, George Alleyne, Kenneth J Arrow, Seth Berkley, Agnes Binagwaho, Flavia Bustreo, David Evans, Richard G A Feachem, Julio Frenk, Gargee Ghosh, Sue J Goldie, Yan Guo, Sanjeev Gupta, Richard Horton, Margaret E Kruk, Adel Mahmoud, Linah K Mohohlo, Mthuli Ncube, Ariel Pablos-Mendez, K Srinath Reddy, Helen Saxenian, Agnes Soucat, Karen H Ulltveit-Moe, Gavin Yamey*

2015-2035: Three Domains of Health Challenges



THE LANCET GLOBAL HEALTH 2035

Global Health 2035: 4 Key Messages

A **grand convergence** in health is achievable within our lifetime

The **returns from investing in health** are extremely impressive

Fiscal policies are a powerful, underused lever for curbing non-communicable diseases and injuries

Progressive pathways to **universal health coverage** are an efficient way to achieve health and financial protection

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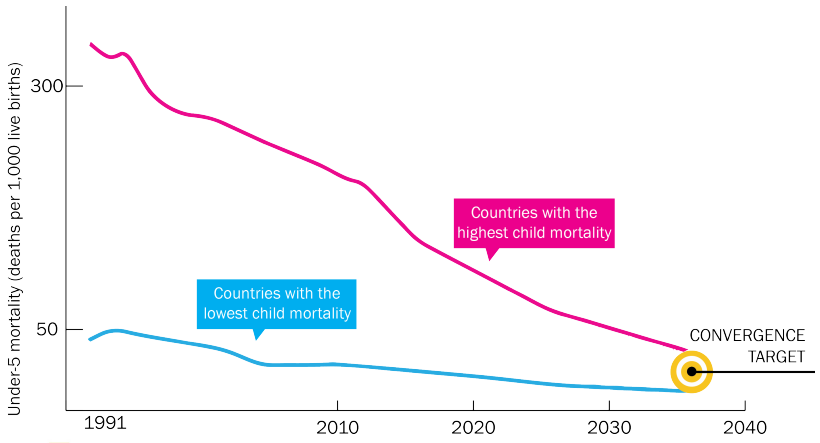
Now on Cusp of a Historical Achievement: *Nearly All Countries* Could Converge by 2035



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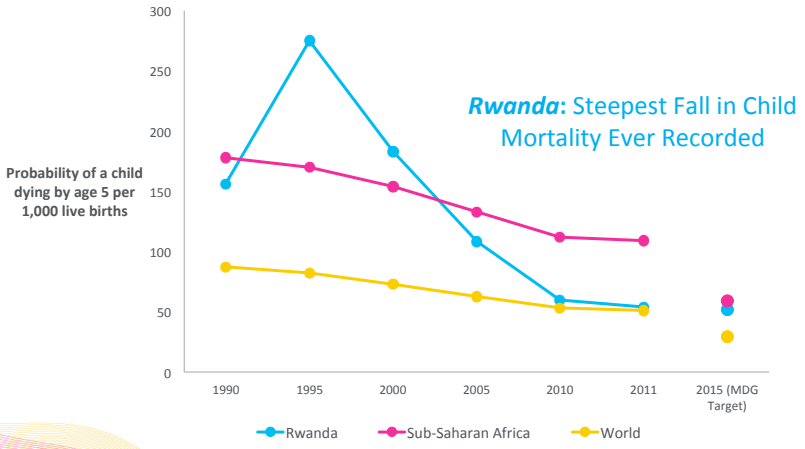
Investment ($70B/year) is Not a High Risk Venture: Rapid Mortality Decline Is Possible



Farmer P, et al. *BMJ 2013; 346:* f65

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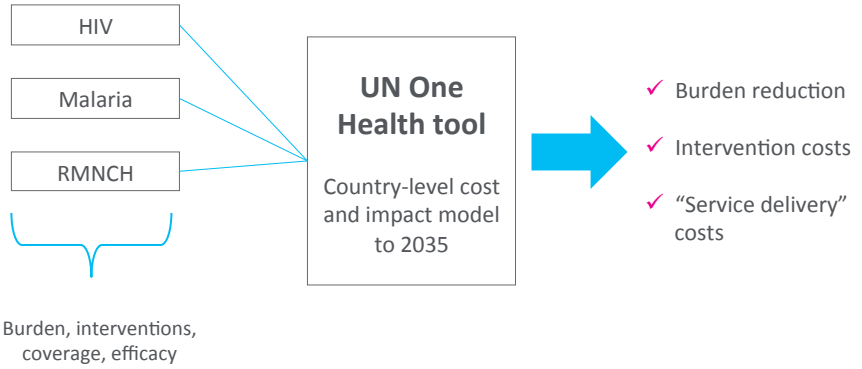
Modeling Convergence Investment Case[1]

Compares scale-up versus constant coverage



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Full Income: A Better Way to Measure the Returns from Investing in Health

income growth + value life years gained (VLYs) in that period = change in country's **full income** over a time period

Between 2000 and 2011, about a quarter of the growth in full income in low-income and middle-income countries resulted from VLYs gained

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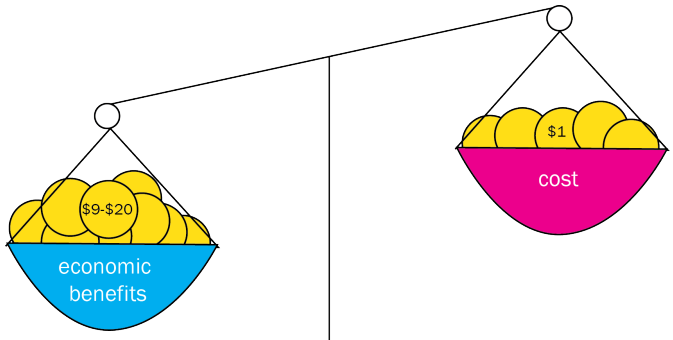
With Full Income Approach, Convergence Has Impressive Benefit: Cost Ratio



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Sources of Financing for Convergence

Economic growth	Mobilization of domestic resources	Inter-sectoral reallocations and efficiency gains	Development assistance for health
• IMF estimates $9.6 trillion/y from 2015-2035 in low- and lower middle-income countries • **Cost of convergence ($70 billion/y) is less than 1% of anticipated growth**	• Taxation of tobacco, alcohol, sugar "win-wins" • Broadening and strengthening tax base	• Removal of fossil fuel subsidies, health sector efficiency • Subsidies account for an 3.5% of GDP on a post-tax basis	• Will still be crucial for achieving convergence

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Single Greatest Opportunity To Curb NCDs is Tobacco Taxation

50% rise in tobacco price from tax increases in China

- prevents 20 million deaths + generates extra $20 billion/y in next 50 y
- additional tax revenue would fall over time **but** would be higher than current levels even after 50 y
- largest share of life-years gained is in bottom income quintile

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We Also Argue for Taxes on Sugar e.g. product taxes on Sugar-Sweetened Sodas

- Taxing empty calories, e.g. sugary sodas, can reduce prevalence of obesity and raise public revenue
- These taxes do not hurt the poor: main dietary problem in low-income groups is *poor dietary quality* and not energy insufficiency

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Lessons from Taxing Tobacco and Alcohol

- Taxes must be **large** to change consumption
- Must prevent **tax avoidance** (loopholes) and **tax evasion** (smuggling, bootlegging)
- Design taxes to **avoid substitution**
- **Young/low-income groups** respond most

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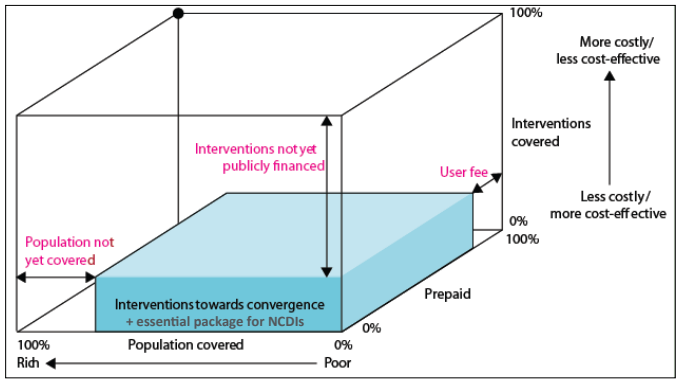
Our Recommendation on UHC: Progressive Universalism (Blue Shading)



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Progressive Universalism

- Insurance covers whole population
- Targets poor by insuring highly cost-effective health interventions for diseases disproportionately affecting poor
- Interventions are funded through tax revenues, payroll taxes, or combination
- No OOP expenses for defined benefit package of publicly financed services
- As resource envelope grows, so does package (as seen in Mexico), e.g. add wider range of interventions for NCDs

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Advantages of Progressive Universalism

- Government does not have to incur costly administrative expenses identifying who is poor (*everyone is covered*)
- Universal package promotes broader support among population and health providers than schemes targeting poor alone—such support helps to sustain financing over time

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A Variant of Progressive Universalism

- *Larger package* to whole population *with patient copayment* but *poor are exempted from copay* (e.g. Rwanda)
- Uses a wider variety of financing mechanisms (general taxation, payroll tax, mandatory insurance premiums, copayments)

Advantages: wider package, engages non-poor in prepaid mandatory scheme from day 1, transition may be more feasible

Major disadvantage: costly to identify poor, to organize and collect copays/ premiums

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Thank you

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THE LANCET GLOBAL HEALTH 2035

Caveats & Challenges

- Inherent uncertainties in any modeling exercise
- Assumes aggressive coverage levels (typically 90-95% by 2035)—would all countries have the institutional capacity?
- Model does not account for role of other development sectors (e.g. climate, water) or social determinants of health
- May over-play or under-play role of R&D

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