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

2015-2035: Three Domains of Health Challenges

- High rates of avoidable infectious, child, and maternal deaths
- Demographic change and shift in GBD towards NCDs and injuries
- Impoverishing medical expenses, unproductive cost increases

Unfinished agenda
Emerging agenda
Cost agenda

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

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

*Rwanda: Steepest Fall in Child Mortality Ever Recorded*

Modeling Convergence Investment Case

Compares scale-up versus constant coverage

UN One Health tool
Country-level cost and impact model to 2035

- Burden reduction
- Intervention costs
- “Service delivery” costs

Burden, interventions, coverage, efficacy

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

\[
\text{income growth} + \text{value life years gained (VLYs) in that period} = \text{change in country's full income over a time period}
\]

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

With Full Income Approach, Convergence Has Impressive Benefit: Cost Ratio
Sources of Financing for Convergence

**Economic growth**
- 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

**Mobilization of domestic resources**
- Taxation of tobacco, alcohol, sugar “win-wins”
- Broadening and strengthening tax base

**Inter-sectoral reallocations and efficiency gains**
- Removal of fossil fuel subsidies, health sector efficiency
- Subsidies account for an 3.5% of GDP on a post-tax basis

**Development assistance for health**
- 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

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
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)

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
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

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
Thank you

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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