G7 Support for Global Health and Japan's G7 Agenda for Universal Health Coverage

A webinar with the G7 Global Taskforce & the Commission on Investing in Health Secretariat

presented by

Gavin Yamey

Professor of the Practice of Global Health and Public Policy, Duke Global Health Institute

April 20, 2016

GLOBAL HEALTH 2035

Who is on today's webinar?

Please share your **name**, **affiliation**, and **where** you are joining from

→ use the chat box

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Welcome G7 Global Taskforce Members!

Kel Currah
Chair of the G7 Global Taskforce

Webinar objectives:

- To share new analyses on the G7's support for global health, conducted by the Commission on Investing in Health Secretariat
- Discuss implications for Japan, the G7, and global health advocacy

Questions encouraged throughout the presentation!

→ use the chat box

Introducing Gavin Yamey

- Led the writing of the Commission on Investing in Health's *Global Health 2035* report
- Leads the Commission's Secretariat, which helps inform global health financing priorities among donors and low- and middle-income countries
- Directs the Center for Policy Impact in Global Health at Duke

Gavin Yamey
Professor of the Practice of Global Health and Public Policy, Duke Global Health Institute

Quick agenda

- Background on the Commission on Investing in Health and "global functions"
- Results from new analysis on G7 support for global health by function
- Discussion of implications for the G7 and global health advocacy

- Analysis by the Commission on Investing for Health Secretariat

- Partnership with the Japan Global Health Working Group for the 2016 Ise-Shima G7 Summit

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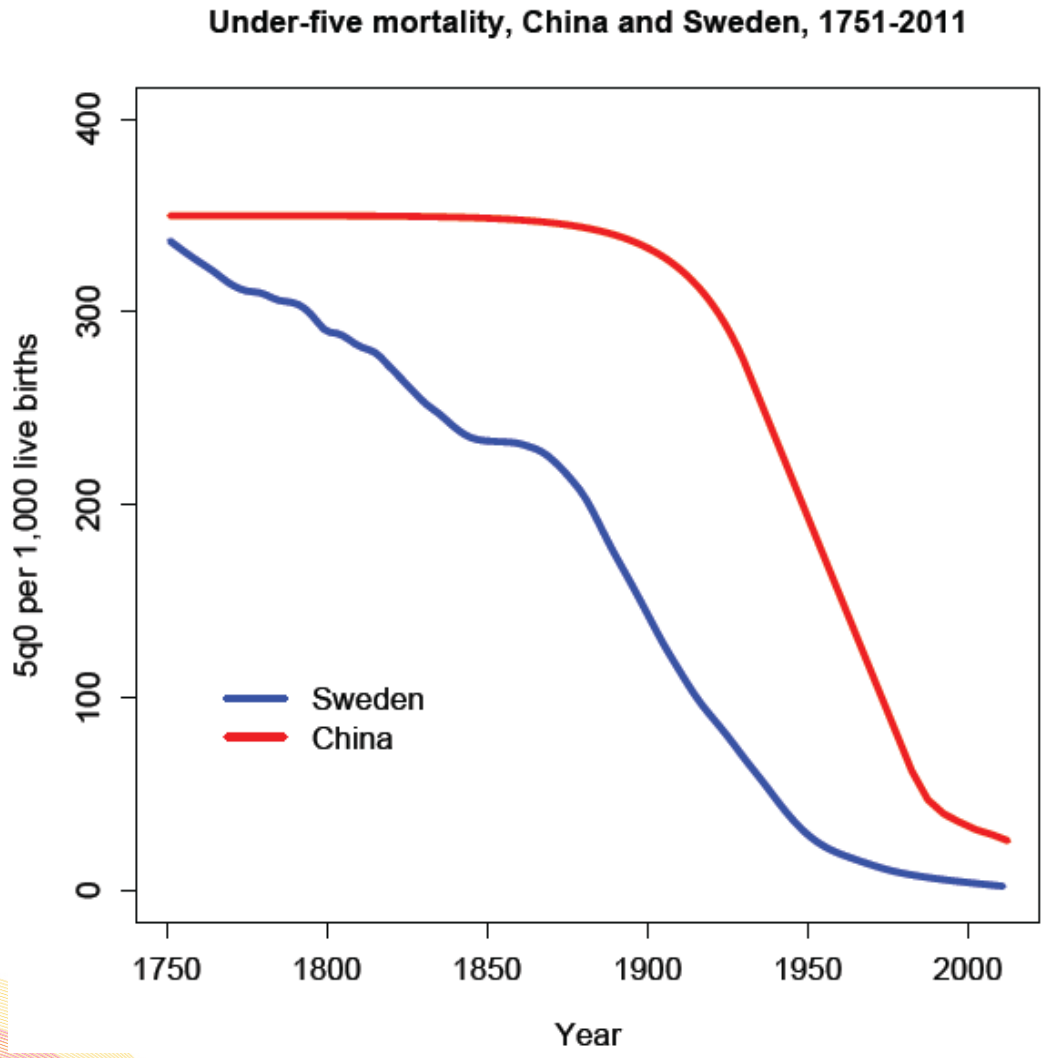
THE LANCET

Global health 2035: a world converging within a generation

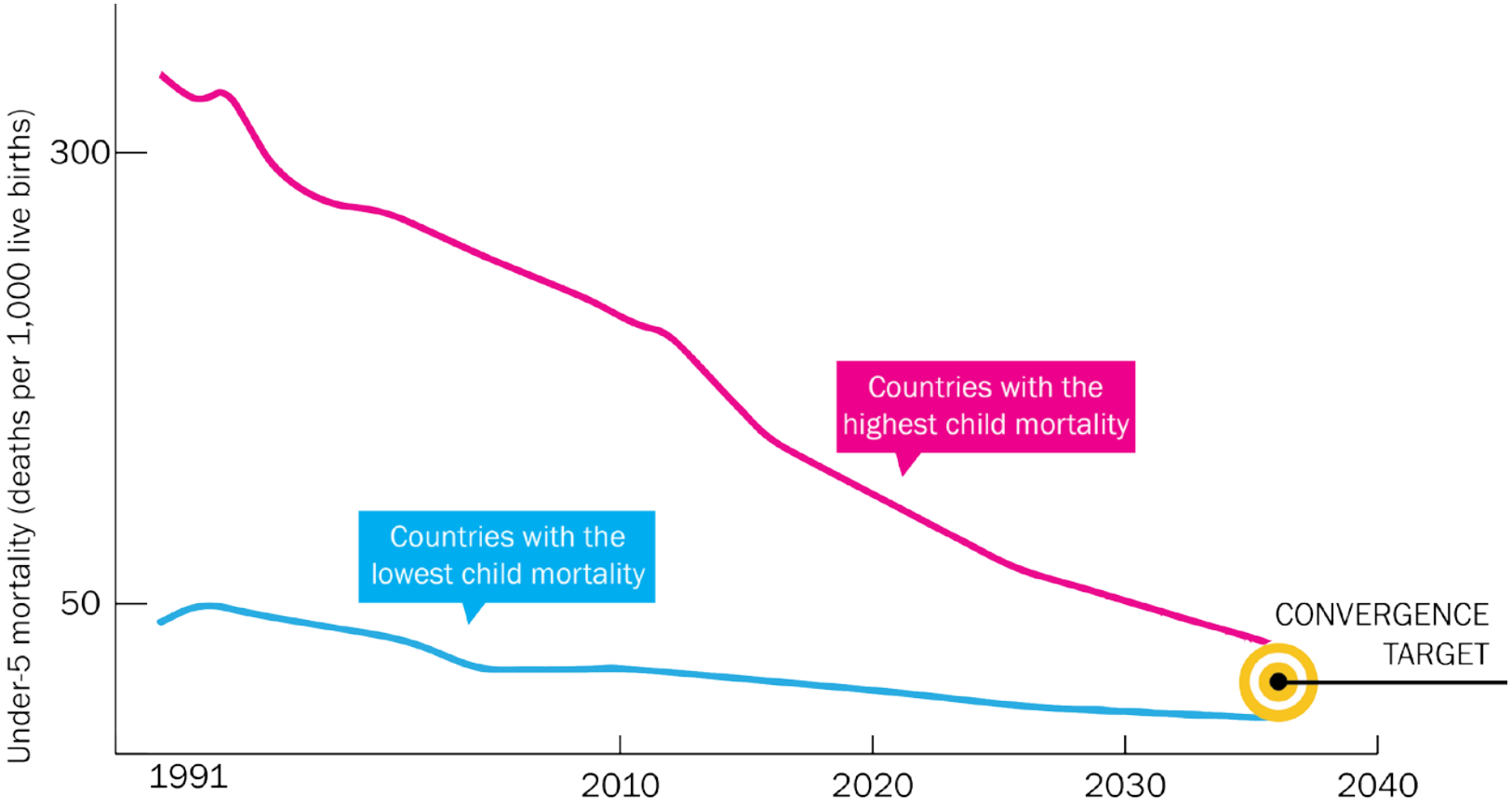
Dean T Jamison, Lawrence H Summers*, George Alleyne, Kenneth J Arrow, Seth Berkley, Agnes Binagwaho, Flavia Bustreo, David Evans, Richard G A Feachem, Julio Frenk, Gargee Ghosh, Sue J Goldie, Yan Guo, Sanjeev Gupta, Richard Horton, Margaret E Kruk, Adel Mahmoud, Linah K Mohohlo, Mthuli Ncube, Ariel Pablos-Mendez,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

THE LANCET GLOBAL HEALTH 2035

Convergence, divergence, and a second convergence



Now on cusp of a historical achievement: *Nearly all countries* could converge by 2035



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Sources of income to fund convergence

Economic growth	Mobilization of domestic resources	Inter-sectoral reallocations and efficiency gains	Development assistance for health
• IMF estimates low- and lower middle-income countries will add $9.6 trillion/y to GDP from 2015-2035 • **Cost of convergence ($70 billion/y) is less than 1% of anticipated growth**	• Taxation of tobacco, alcohol, sugar, extractive industries	• Redirection of fossil fuel subsidies to the health sector, health sector efficiency • Subsidies account for 3.5% of GDP on a post-tax basis	• Will still be crucial for achieving convergence • The *nature* of DAH will need to evolve – more emphasis on R&D, pandemic preparedness and other "global" functions

High-level studies argue that ODA needs to evolve to support global functions – CIH continues to shape this discussion

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Chatham House Report

May 2014

Shared Responsibilities for Health

A Coherent Global Framework for Health Financing

Final Report of the Centre on Global Health Security Working Group on Health Financing

How much donor financing for health is channelled to global versus country-specific aid functions?

Marco Schäferhoff, Sara Fewer, Jessica Kraus, Emil Richter, Lawrence H Summers, Jesper Sundewall, Gavin Yamey, Dean T Jamison

Georgetown University Law Center

Scholarship @ GEORGETOWN LAW

2014

Ebola: A Crisis in Global Health Leadership

Lawrence O. Gostin
Georgetown University Law Center, gostin@law.georgetown.edu

Eric A. Friedman
Georgetown University Law Center, eaf74@law.georgetown.edu

Report of the Consultative Expert Working Group on Research and Development: Financing and Coordination

World Health Organization

The Next Epidemic — Lessons from Ebola

Bill Gates

N Engl J Med 2015; 372:1381-1384 | April 9, 2015 | DOI: 10.1056/NEJMp1502918

GLOBAL HEALTH 2035

What are global functions?
An alternative classification of donor financing for health

GLOBAL FUNCTIONS	
Supplying global public goods (GPGs)	• R&D for health tools • Development of norms, standards and guidelines • Knowledge generation and sharing • Intellectual property sharing • Market-shaping activities
Managing cross-border externalities	• Outbreak preparedness and response • Responses to antimicrobial resistance • Responses to marketing of unhealthful products • Control of cross-border disease movement
Exercising leadership & stewardship	• Health advocacy and priority setting • Promotion of aid effectiveness and accountability
COUNTRY-SPECIFIC FUNCTIONS	
Providing support to LICs & MICs for country-specific purposes	• Achieving convergence • Controlling NCDs and injuries • Health-systems strengthening

Why do global functions matter?

- Investments in global functions are needed to tackle major global health problems and risks:
  - Pandemic flu
  - Antibiotic drug resistance
  - Cross-border externalities

- Costs of inaction are very high – e.g. West Africa will loose US$15 billion over next 3 years due to Ebola outbreak

- To achieve grand convergence – urgent need for increased investments in R&D for neglected, poverty-related diseases

- Efficient way to support middle-income countries: as countries become increasingly able to self-finance their country-specific health needs, MICs benefit from the fruits of support for global functions

- Country-specific support, especially to vulnerable populations, will remain crucial (still ~25 LICs in 2035), but global functions need more investments

Protecting human security:
Proposals for the G7 Ise-Shima Summit in Japan

Global Health Working Group*

THE LANCET
(forthcoming)

The working group recommendations are **dominated by global functions:**

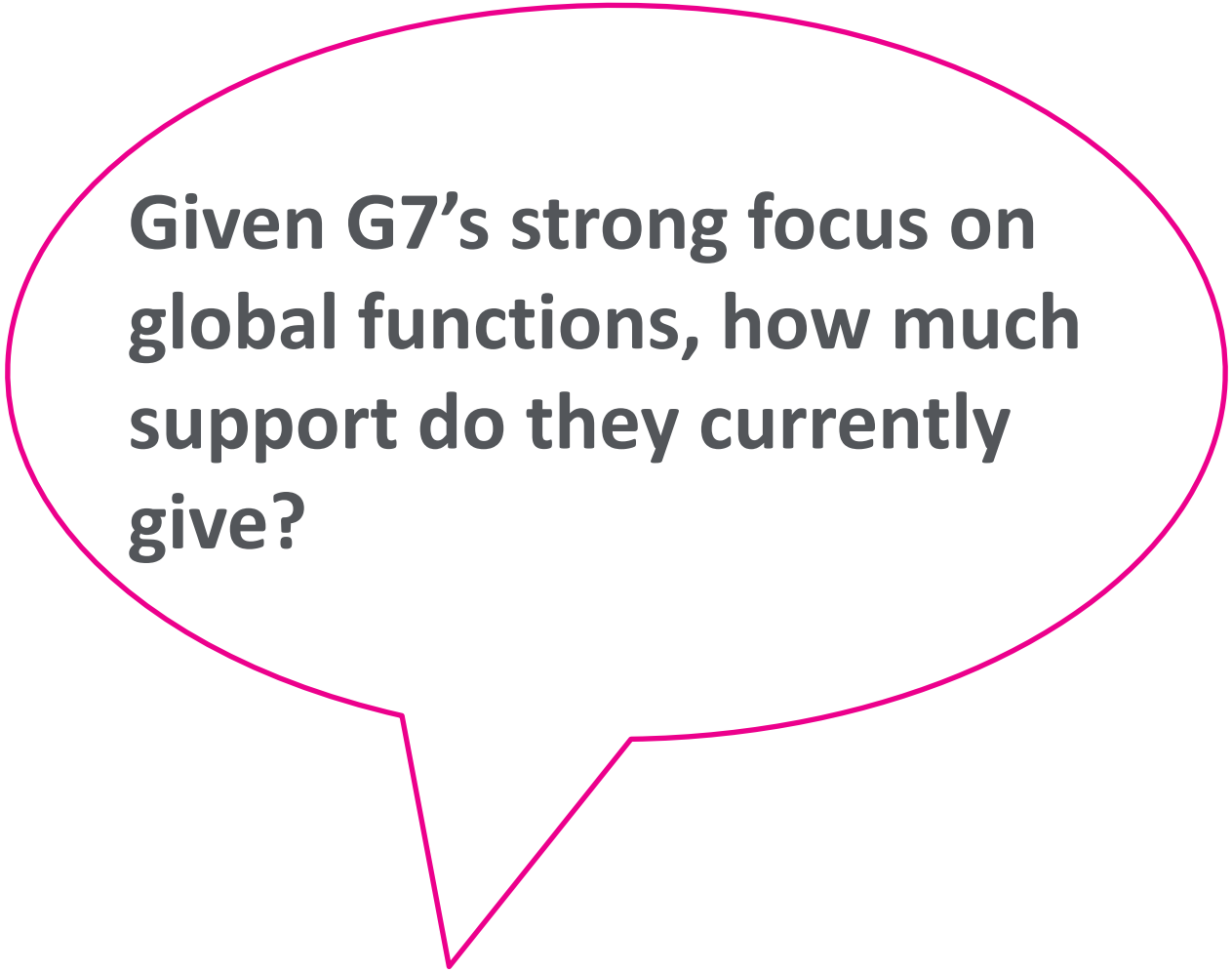
(1) develop a **global health architecture** that enables preparedness and responses to health emergencies
(2) develop **platforms** to share best practices and harness shared learning on the resilience and sustainability of health systems
(3) strengthen **coordination and financing** for R&D and **system innovations** for global health security

11 specific recommendations

*Led by Kenji Shibuya, Department of Global Health Policy, University of Tokyo

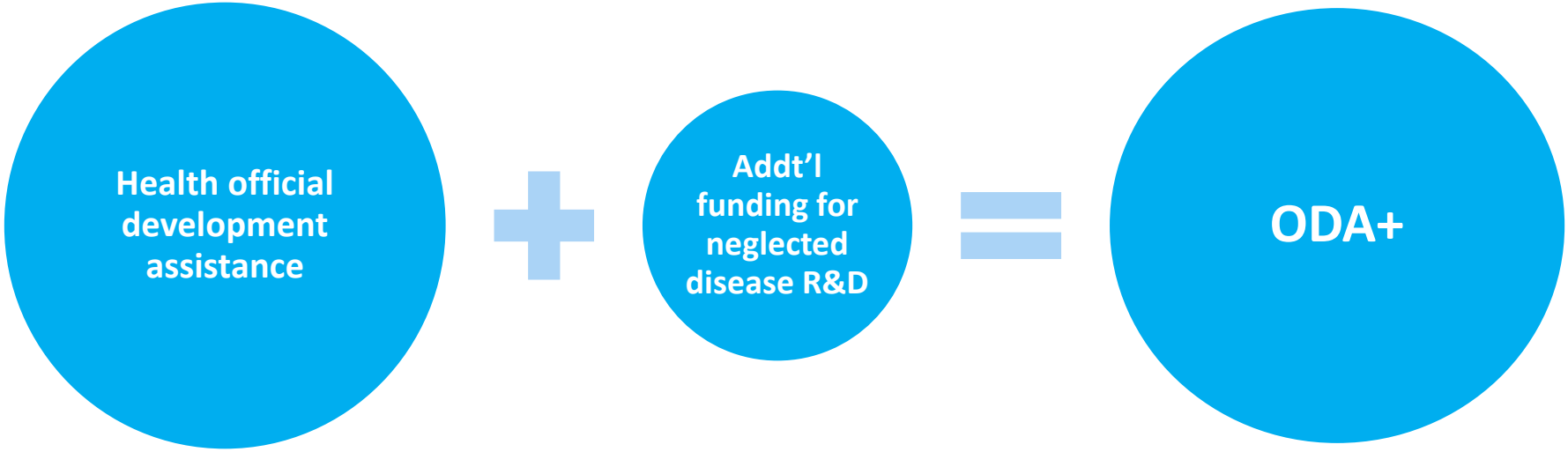
Our analysis of 11 GHWG recommendations

GLOBAL FUNCTIONS	
Supplying global public goods (GPGs)	• Develop platforms to share best practices • Clarify priority diseases/projects for R&D • Double investment in global health R&D
Managing cross-border externalities	• Strengthen WHO framework on outbreak reporting • Pandemic preparedness: support WHO's Contingency Fund for Emergencies and the World Bank's Pandemic Emergency Facility
Providing global leadership & stewardship	• Improve global coordination in health preparedness • Build International Health regulations (IHR) and Global Health Security Agenda (GHSA) core capacities • Advocacy for country-specific M&E • Promote collaboration between health & financial sectors to mobilize domestic funding for health system sustainability
COUNTRY-SPECIFIC FUNCTIONS	
Providing support to LICs, MICs for country-specific purposes	• Integrate HSS into country-specific vertical programs (Global Fund, Gavi) • Support countries to build expertise on health systems analysis


Given G7’s strong focus on global functions, how much support do they currently give?

QUESTION

ODA+ for health: A more comprehensive picture of donor support for health



OECD DAC, Creditor Reporting System (CRS), 2013

- Bilateral health disbursements, using sector codes for health
- Health sector core contributions to multilaterals and partnerships

Policy Cures G-FINDER database, 2013

- Public spending for pharmaceutical R&D for neglected diseases across assessed donors

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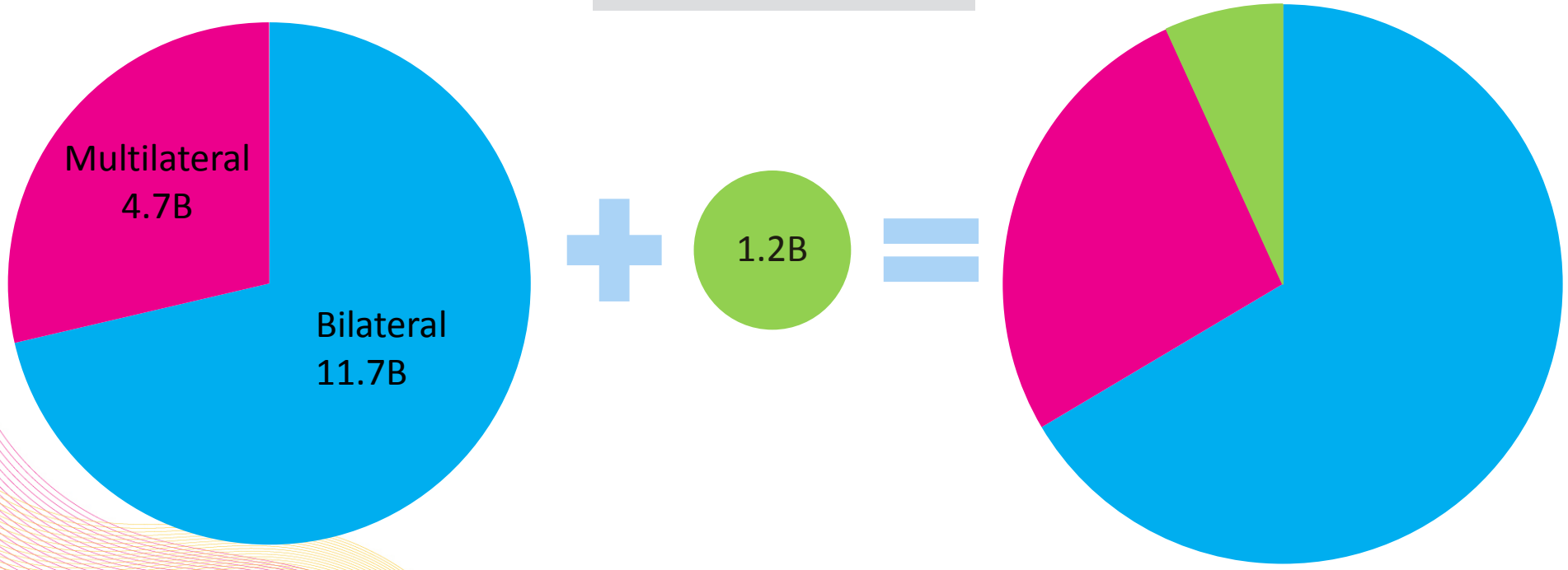
Donor spending by the G7 for ODA+ for health was US$17.6B in 2013

US$16.4B
in ODA for health
(OECD, DAC, 2013)

US$1.2B
in additional funding for neglected disease R&D
(G-FINDER)

US$17.6B for ODA+



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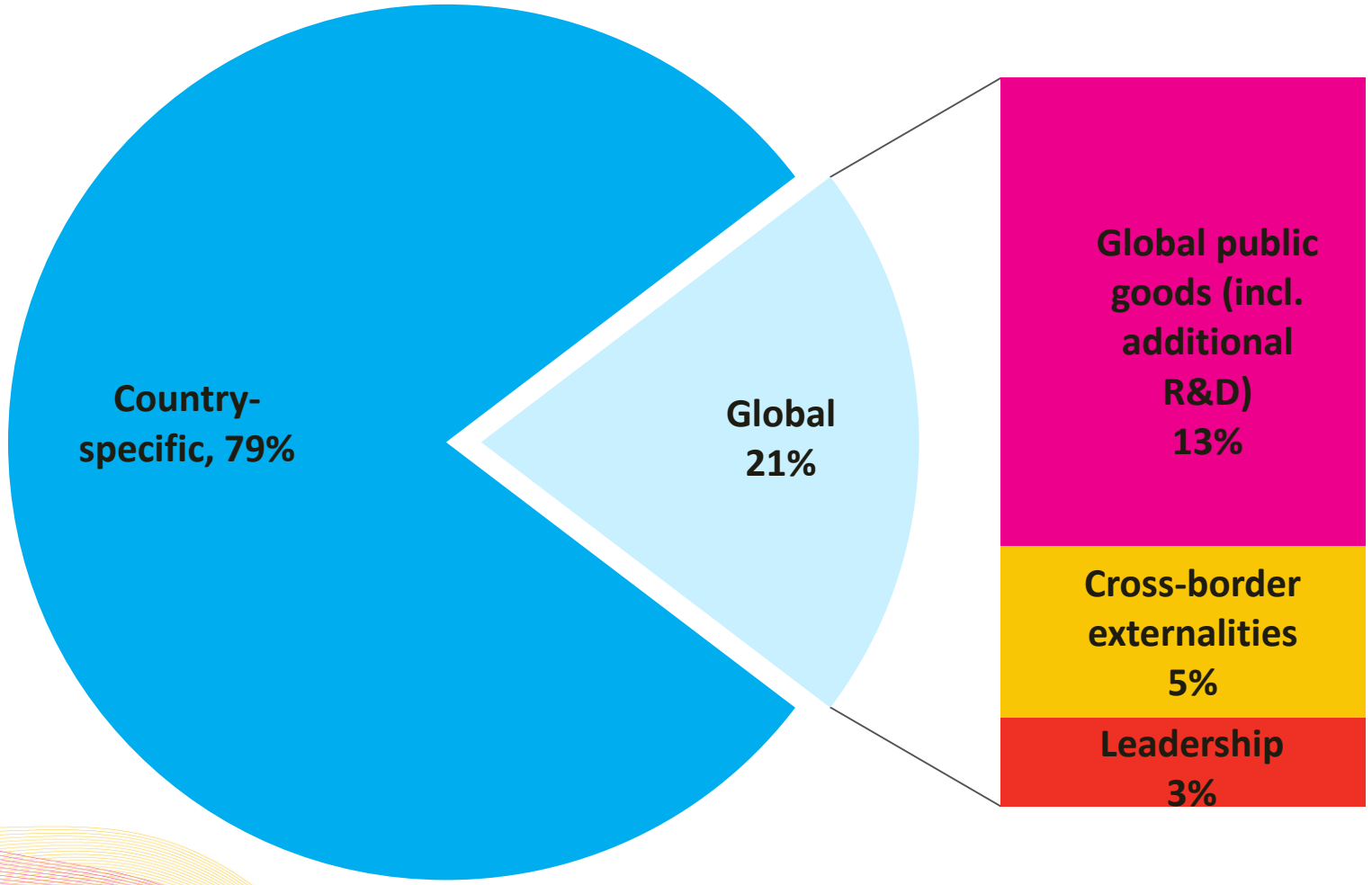
79% of the G7's ODA+ in 2013 was for country-specific support; the largest portion of global support was for GPGs



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Policy-oriented DAH framework using examples from the G7's ODA+ portfolio

Function	Examples from the G7 Portfolio
Supplying **global public goods**	• R&D of new health tools: e.g., support by the US to the Fred Hutchinson Cancer Research for **preventative HIV/AIDS vaccine** • Market-shaping activities: e.g., UK/Canada support to Gavi for its **advance market commitment** of pneumococcal vaccines
Management of **cross-border externalities**	• Eradication efforts: e.g., support for **polio eradication** initiatives (Canada support to UNICEF in Pakistan; Germany support to Nigeria MoH) • Outbreak preparedness: e.g., support from Japan to Vietnam for **biosafety laboratory network** to examine hazardous infectious pathogens
Exercising **leadership and stewardship**	• Global accountability: e.g., a portion of **general support to WHO** by all G7 donors • Leadership: e.g., US support to Management Sciences for Health to increase health **governance knowledge of policy makers** in Afghanistan
Providing **country-specific support**	• Convergence support: e.g., support from France to Benin for providing **MNCH services** in health centers • Basic **health infrastructure**: e.g., support from Italy to Brazil for expansion of a general hospital

The G7 is underinvesting in global functions

Out of total ODA+ for health:

- **Only 21% ($3.6 billion) was spent on all global functions**
  - WHO estimates that $6 billion annually is needed for R&D for neglected diseases alone
- **Only 5% ($880 million) was invested in management of cross-border externalities**
  - The World Bank estimates that $3.4 billion annually is needed to build a pandemic preparedness system across low- and middle-income countries
- **Only 3% was spent on leadership and stewardship**
  - WHO remains a central actor for this role, but its core budget continues to shrink

Support for global functions is necessary for achieving a "grand convergence" and universal health coverage

- **Achieving grand convergence requires R&D**
  - Grand convergence (and SDG3 targets on infectious, maternal, and child deaths) cannot be achieved without new treatments, vaccines, and diagnostics for diseases of poverty
  - R&D is necessary to curb the threat of anti-microbial resistance and future outbreaks
  - Policy and implementation research is needed to scale-up and deliver effective interventions

- **Achieving UHC requires knowledge sharing and stewardship**
  - Over 100 countries have committed to achieving UHC; cross-country learning will be crucial
  - Leadership and stewardship from WHO is essential

Conclusions

- ODA+ for health from G7 countries mostly targets country-specific support
- G7 countries are underinvesting in global functions (i.e., supporting global public goods, controlling cross-border issues, and fostering leadership and stewardship)
- Supporting “global functions” is an important way the G7 can help achieve the SDG goals and respond to future threats

Policy Implications

1. Strengthen support for global functions
   - Only one-fifth of overall ODA+ for health is for all global functions, and even less is estimated as a proportion for Japan

2. As countries graduate from donor support, shift aid towards global functions
   - Efficient way to address “middle-income dilemma”

3. Selective support to middle-income countries for vulnerable groups and politically problematic services

4. Support health service delivery in the poorest countries

Questions?

Please submit your questions and comments

→ use the chat box

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Thank you!

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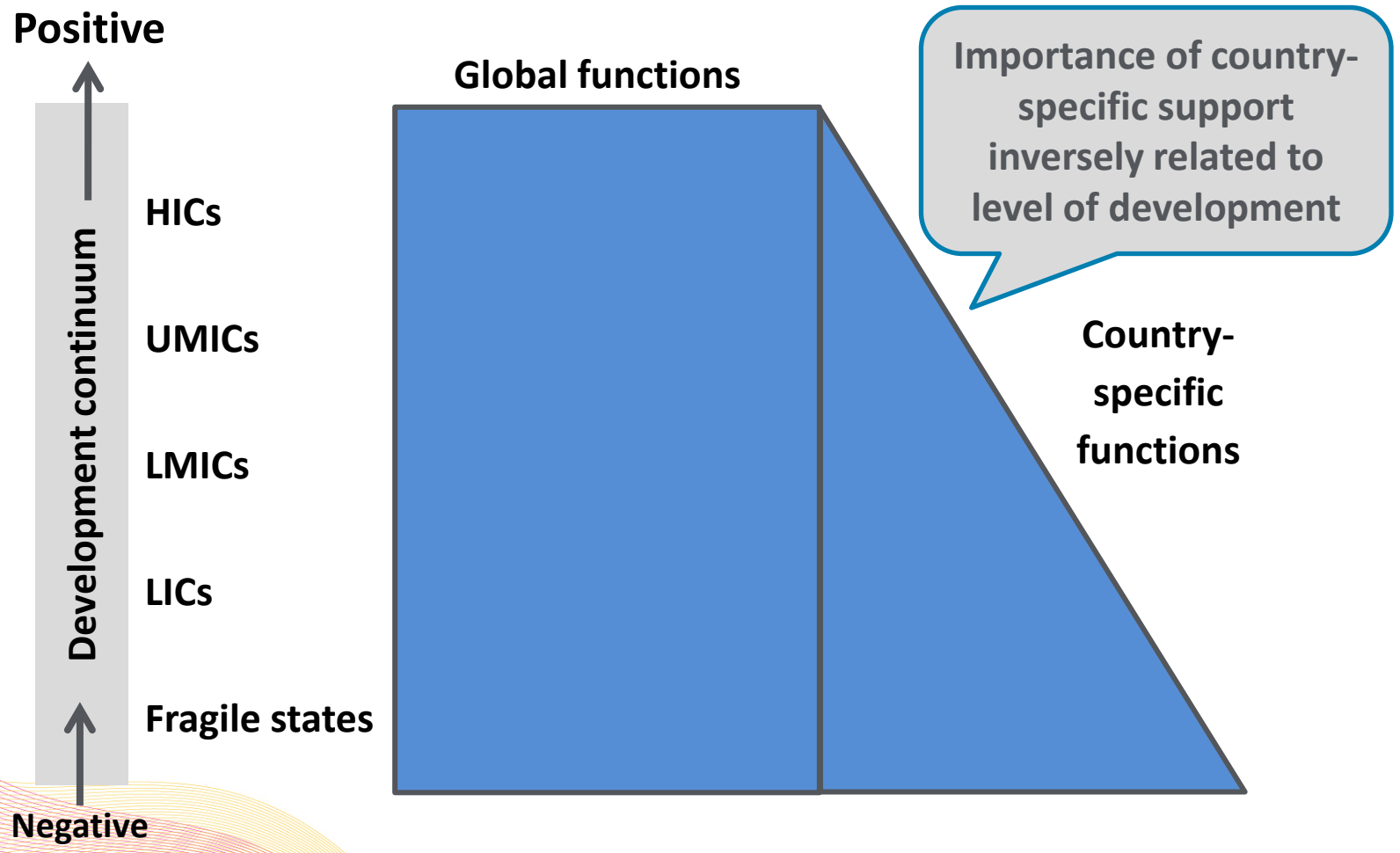
BACKUP SLIDES

As countries get richer, there is less relative need for ODA for routine health services, and greater relative need to finance global functions



Adapted from figure in: Jamison DT, Frenk J, Knaul F. International collective action in l ıd rationale. *Lancet* 1998; 351:514–17.

Rationale for analyzing global function support

1. Previous research (e.g. IHME) has tracked donor funding to specific diseases and geographical regions, but **no in-depth studies have tracked donor funding for global health functions**.

2. Understanding flows to global versus country-specific functions could help to **identify important underfunded areas for future donor investment.**

3. Investments in global functions may lead to **increased effectiveness and efficiency of health aid.**

4. Understanding of extent to which donors focus **country-specific support on low-income vs. middle-income countries** will be important to guide aid investments in the post-2015 era.

5. The ongoing UN agency sponsored Equitable Access Initiative (EAI) addresses issues of future aid allocation but risks focusing discussion on formulas for allocating country-specific aid.