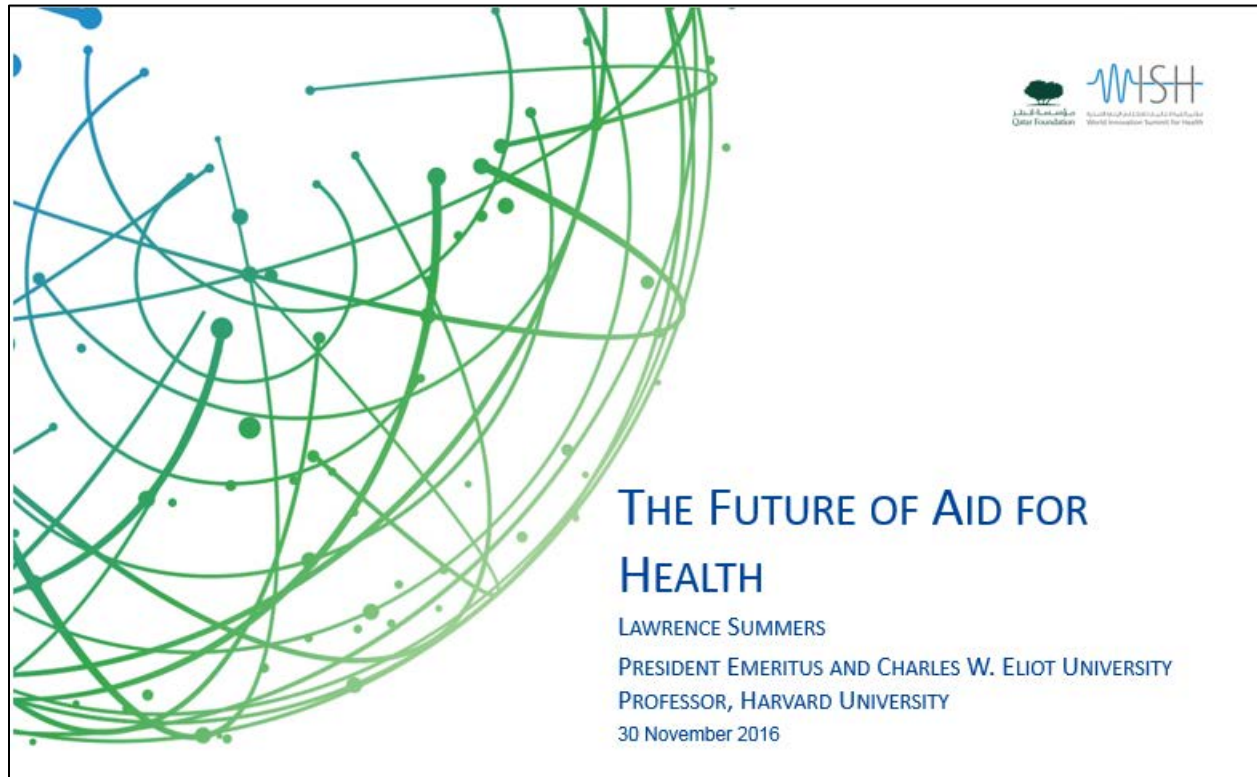


Lawrence Summers' Keynote Address for Doha: The Future of Aid for Health
November 30, 2016



[slide 1]

Opening

You may be asking: why is an economist like me, whose day job is devoted to monetary and fiscal policy, giving the keynote address at the 2016 World Innovation Summit for Health?

It's a fair question.

I have always believed that economics is a moral science because it is so centrally involved with choices that directly affect human well being. And cancer at age 30 reinforced for me that no choices centrally affect human well being as those involving health.

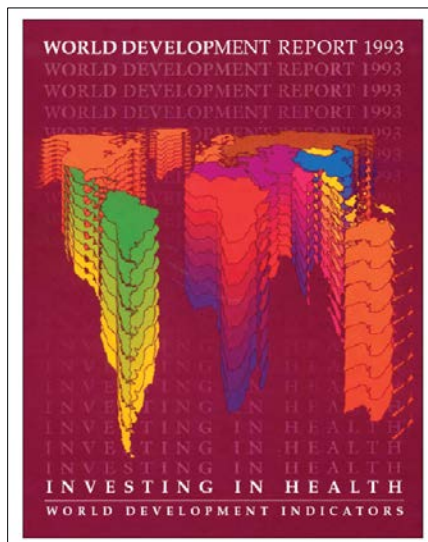
Economics is defined as "the study of the allocation of scarce resources among competing ends". Few if any resources allocation choices are as consequential as those involved with health care.

I am here today because I have become convinced that even as we fight for increases in global health aid, there is a need for a major reorientation of the global aid for health effort away from financing service delivery in individual countries and towards global priorities.

First analysis

Some back ground first

I had the privilege of serving as Chief Economist at the World Bank in the early 1990s. One responsibility of this position is that you get to choose the topic for the Bank's annual flagship publication, the World Development Report, which aims to inform global thinking on a specific issue. I chose global health as the focus of the 1993 report, *Investing in Health* [slide 2] because I wanted to illustrate in an era when economists were focused on austerity and pro market reform that economic analysis could be harnessed to make the case for social investment.



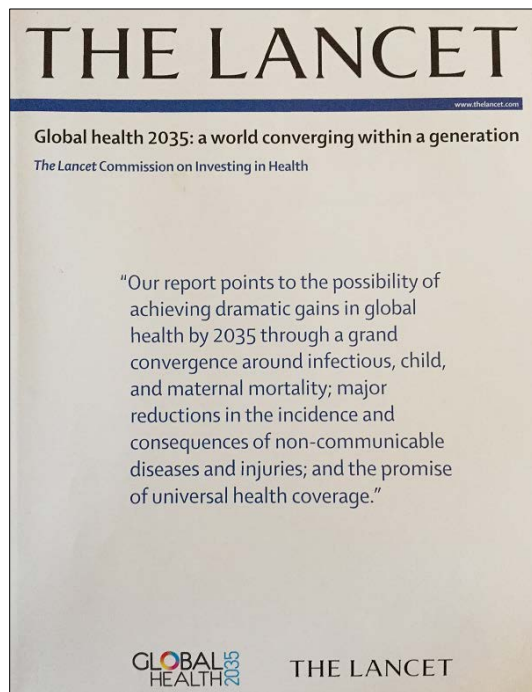
[slide 2]

To the best of my knowledge, *Investing in Health* was the first major health report to be targeted at *finance ministers* rather than health ministers.

It showed finance ministers that well-chosen health expenditures are *not* a drain on the economy. Instead, they are an investment in economic prosperity and individual wellbeing. Our report made the case that, in countries with constrained budgets, allocating resources toward cost-effective interventions for high-burden diseases offered a rapid and inexpensive pathway to improving people's lives.

The Report produced by a team that Dean Jamison led was successful beyond our most optimistic expectations. Indeed Bill Gates has credited it with spurring his interest in devoting much of his philanthropic energy to global health.

To mark the twenty-year anniversary of the 1993 World Development Report, I was asked to chair the Commission on Investing in Health—an international group of leading economists and health experts—which published its report in *The Lancet*, called *Global Health 2035* [slide 3].

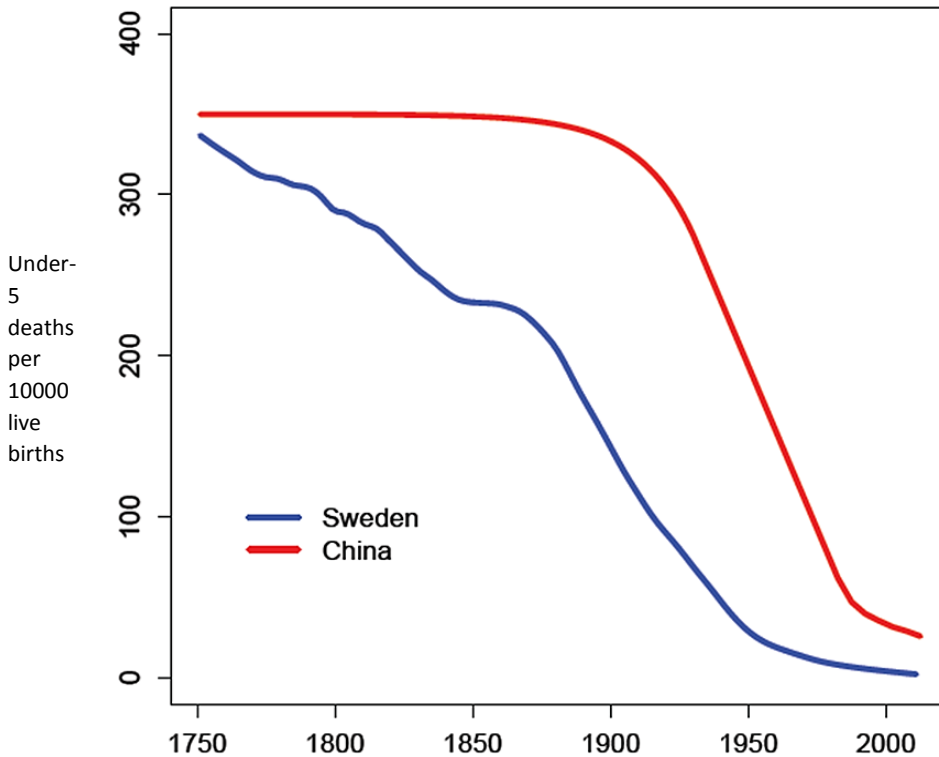


[slide 3]

Global Health 2035 laid out an ambitious investment framework to achieve what we called a “grand convergence” in global health by 2035. By grand convergence, we mean all countries improving their population health to a *universally high status*.

When we look at the broad sweep of human history, as you can see illustrated in this graph [slide 4], convergence was the norm. Population health clustered worldwide around a *universally low status*. Death rates for mothers and children were high. While there was modest variation across space and time, life expectancy was short. Everywhere. This kind of misery was the universal condition.

Under-5 mortality, China and Sweden, 1751-2011



[slide 4]

But in the past two centuries we have seen the world diverge.

Advancements in science and investments in public health brought vastly improved health conditions to citizens in the rich, Western world, as you can see in Sweden. Those in the poorest countries, like China, were left behind.

The result was “a great divergence” in global health. Countries diverged more and more until the middle of the twentieth century.

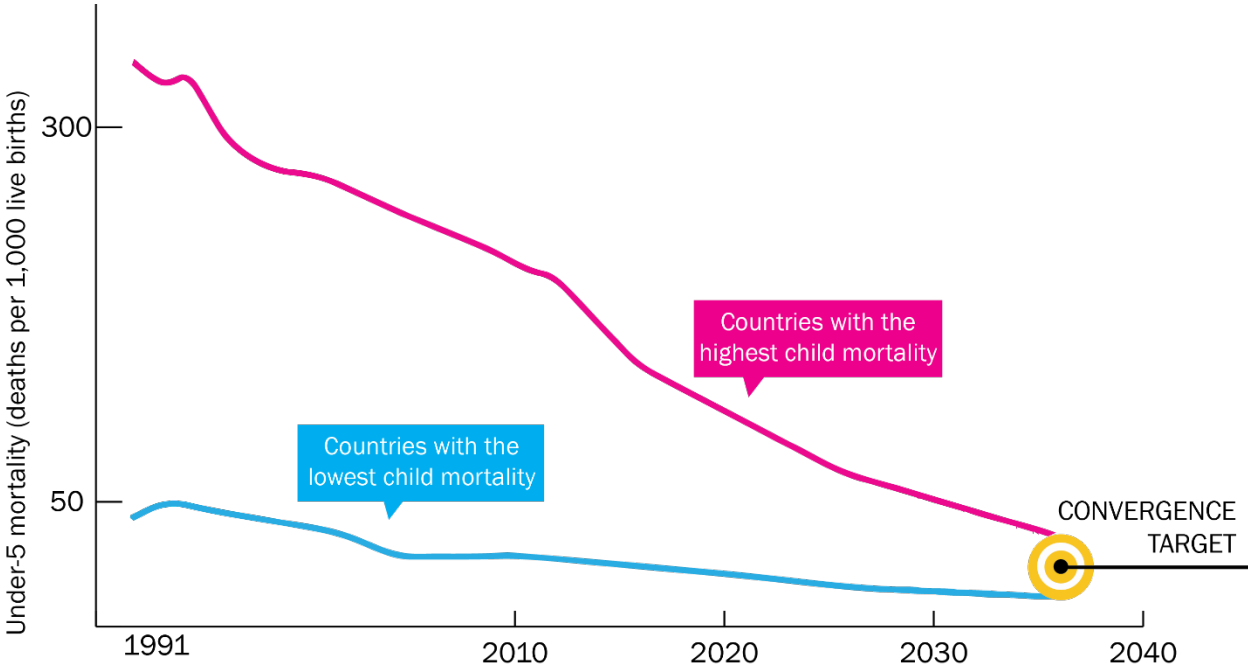
Then was a start towards global convergence, but this convergence is far from complete: today, only one in 150 children in the United States or Britain dies before the age of five versus a rate of one in 10 children in the world’s poorest countries.

Global Health 2035 showed that we are now at a remarkable inflection point in history.

We have seen that countries like China, Chile, Costa Rica, and Cuba—what we can call the “4C countries”—were able to rapidly converge on the mortality levels of the rich world by focused investments in scaling up medicines, vaccines, and other health tools.

Our report found that with the *right health investments* by donors and low- and middle-income countries themselves, nearly all countries could achieve a “grand convergence” in global health within just one generation [slide 5].

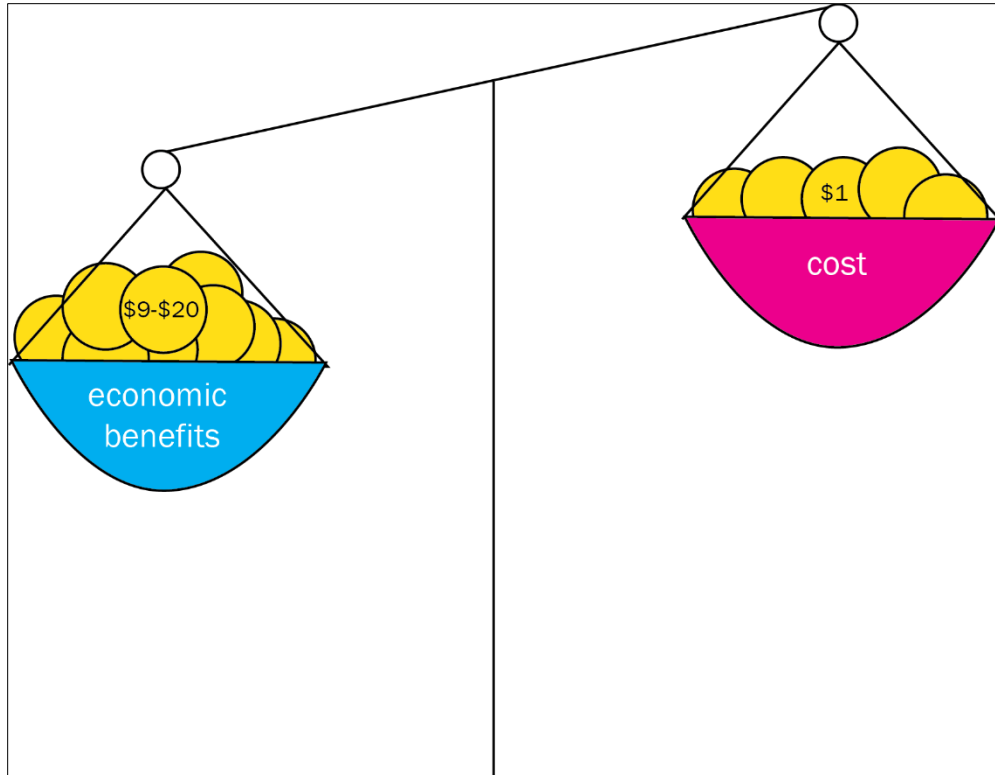
Reconvergence in health, this time at a high level is literally a once in human history possibility, and it is here for the taking in the next generation.



[slide 5]

Transition | Continued interest in health

Funds invested in achieving a grand convergence, for example, over the period 2015-2035 would return benefits on average worth between 9 and 20 dollars [slide 6]. Such returns are extraordinary. Certainly at a time when rich countries can borrow money in real terms at zero, foreseeable returns of this magnitude do not exist in financial markets.

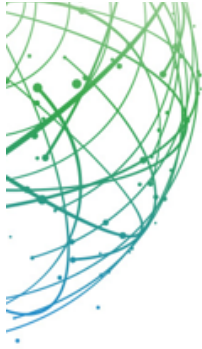


[slide 6]

And, to take this further, when you compare the incremental aid effectiveness of different kinds of aid—aid for education, health, transport, or administration—the highest bang for the buck is from health aid.

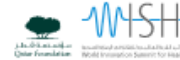
In 2012, a group of eminent economists, including some Nobel laureates, were asked to answer the question: if you could spend \$75 billion to scale up existing interventions to improve the lives of the world's poorest people, what would you prioritize? They used incremental aid effectiveness to rank their priorities.

Here you see their top ten rankings [slide 7]. Eight out of 10 are health sector interventions, the ones shown in red.



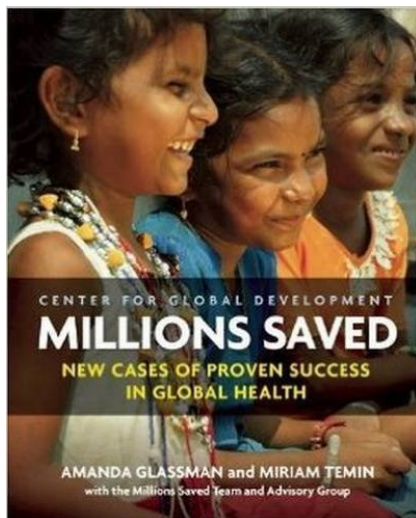
Copenhagen Consensus Priorities, 2012

Rank	Intervention
1	Micronutrients
2	Subsidies for malaria combination treatment
3	Expanding childhood immunization
4	Expanding TB treatment
5	Deworming school children
6	Increasing crop yields
7	Early warning systems to protect people against natural disaster
8	Strengthening surgical capacity
9	Hepatitis B immunization
10	Low cost drugs to treat heart attacks



[slide 7]

Further examples can be found in a remarkable publication from the Center for Global Development, called *Millions Saved*, a collection of case studies cases in which large-scale efforts to improve health in developing countries have succeeded and been highly cost-effective [slide 8].



[slide 8]

Bold proposition | reallocation of aid

Today, I want to provoke you by developing one particular theme that was just a minor key in *Global Health 2035*. I believe it has become a theme of immense importance and urgency.

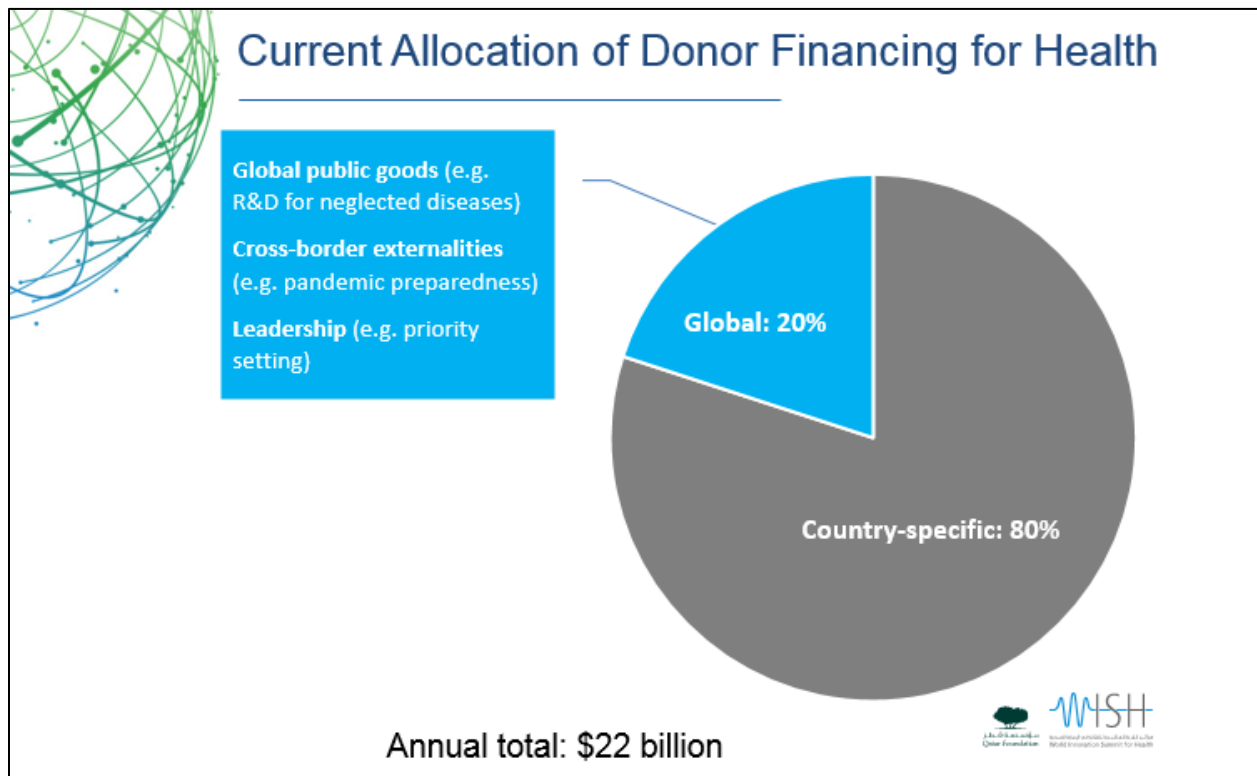
In fact, it is no exaggeration to say that the future of the world’s health depends on it.

My assertion is that we need a major rethink of the global health enterprise.

Right now, about 80% of donor support for health goes towards helping individual countries [slide 9] and only 20% towards tackling *global challenges*—those that go beyond a single nation state.

This must change.

There should be a substantial reallocation of our international health assistance towards the “global functions” of health aid—those that tackle transnational challenges: *providing global public goods*, like developing medicines and vaccines for diseases of poverty; *managing cross-border externalities*, like pandemic preparedness and tackling antimicrobial resistance; and *fostering global health leadership and stewardship*, like improving our priority setting processes.



2

[slide 9]

3 key arguments | laying the groundwork

I am going to base my argument for this reallocation on three considerations.

First, I'll suggest that, for a variety of reasons, direct donor support towards a country's domestic efforts is inferior to a country using its *own domestic resources for health*.

Second, related to this first line of evidence, I'll make the case that the anticipated economic growth of low- and middle-income countries will allow many of these countries to spend more and more of their own resources on their health sector, freeing them from aid dependence.

And third, I'll argue that the highest returns on investment come from investment in global approaches.

I'll end by proposing a suggested time frame for the reallocation of aid to global functions.

First argument | donor support is inferior

As an economist, when I dispassionately compare a country's own support for health sector improvement with external donor support, I see a number of factors that can undermine the impact of aid.

Most important and most often ignored is the phenomenon of fungibility. As a university president I saw this every day. A donor gave us a professorship in say mathematics. Knowing of the new professorship we reallocated budget from mathematics to other fields. The result of the donor's gift was not more mathematics research--it was more budget for the university overall.

In the same way, studies have repeatedly demonstrated that foreign aid earmarked for health or education or anything else translates much less than dollar for dollar into extra spending.

There's also the question of sustainability. What happens when the aid inflows stop? As the old adage goes, give someone a fish and they will eat for one day, but teach them to fish and they will eat forever.

I will never forget my visit to Cote D'Ivoire as we worked on the World Bank Health Report. I was taken on a tour of a gleaming new clinic financed from foreign aid. When I remarked to the health minister the next day on how terrific the clinic seemed, he agreed but noted that half the skilled doctor managers in his country had been hired away from his ministry and were now working in that clinic to the benefit of its patients but to the great detriment of the vast majority of the citizens of his country. But unfortunately, only a tiny percentage of the population was being served by these facilities.

Finally, Inflows of foreign currency into a country—let’s call it Country X—can have a negative impact on its economy.

Foreign aid inflows lead Country X’s currency to appreciate compared to other nations’ currencies, as seen in the foreign exchange rate. The result is that Country X’s exports become more expensive for other countries to buy—therefore impeding exports and economic development.

This is not a hypothetical. Indeed it is usually regarded by economists as a major reason why countries apparently blessed with natural resources and therefore easy access to foreign currency often struggle to develop.

There are some countries facing highly straitened circumstances, like fragile or post-conflict states, where there is certainly a role for direct country-specific health aid. In this situation, the national government is unable to fulfil its domestic responsibilities independently and the international community must step in.

But on current trends the number of such countries is diminishing and in two decades there will probably be only around two dozen or so of these countries.

Second argument | countries are getting richer

Which brings me to my second argument—the anticipated economic growth of low- and middle-income countries.

Perhaps the most striking finding of our *Global Health 2035* report was this: while grand convergence will require about 70 billion dollars per year in incremental health investments—in service delivery no small amount—that cost represents *less than one percent* of the additional GDP that will be available to low- and lower-middle-income countries due to their increased GDP growth over the next 20 years.

Let me repeat that.

An investment by governments of less than one percent of incremental GDP growth would be enough to achieve convergence, averting 10 million deaths each year from 2035 onwards.

That surely represents the single greatest opportunity available on the planet to improve human welfare. Fortunately, in the vast majority of the world the resources necessary for local investments are available locally.

Third argument | global functions have the highest ROIs

Foreign aid in support of service delivery is problematic, and local resources are sufficient for local investment. The last point I want to stress is that we get the highest returns on aid investments when we spend them on global public goods and other global functions.

There is a classic economic principle here--the free rider problem. If a country invests in better health clinics its citizens capture all the benefits of the investment. If it invests in pandemic preparation or vaccine research or development of new service delivery techniques the benefits flow around the world. So it stands to reason that without global cooperation the world will underinvest in global public goods and global functions.

Here's a thought exercise that my Harvard colleague Barry Bloom once posed to me.

Take yourself back to the 1953 polio epidemic. You have an opportunity to make an investment. You have two choices.

You can invest in iron lungs [slide 10]. Or you can invest in Sabin and Salk's efforts to develop a polio vaccine—a global public good.

The March of Dimes charity chose the latter.

They invested about US\$26 million in developing the vaccine.

Since routine vaccination was introduced in the United States, more than 160,000 polio deaths and about 1.1 million cases of paralytic polio have been prevented.

Treatment cost savings have generated a net benefit of around \$180 billion.

Today the world stands at the brink of eradicating polio altogether.

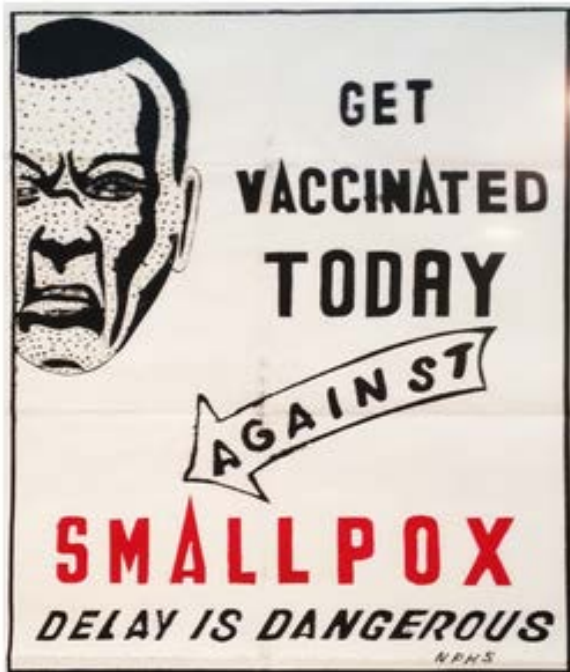
It's hard to think of a better \$26 million investment in human history.



[slide 10]

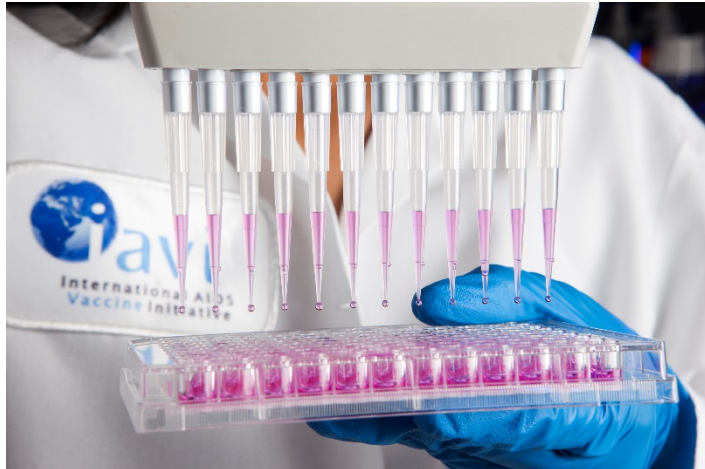
The payoff to these kinds of global goods can be immense. Let me give just you three other examples—and there are many.

- The total cost of eradicating smallpox was around \$300 million [slide 11]. But eradication has led to annual cost savings of over \$2 billion.



[slide 11]

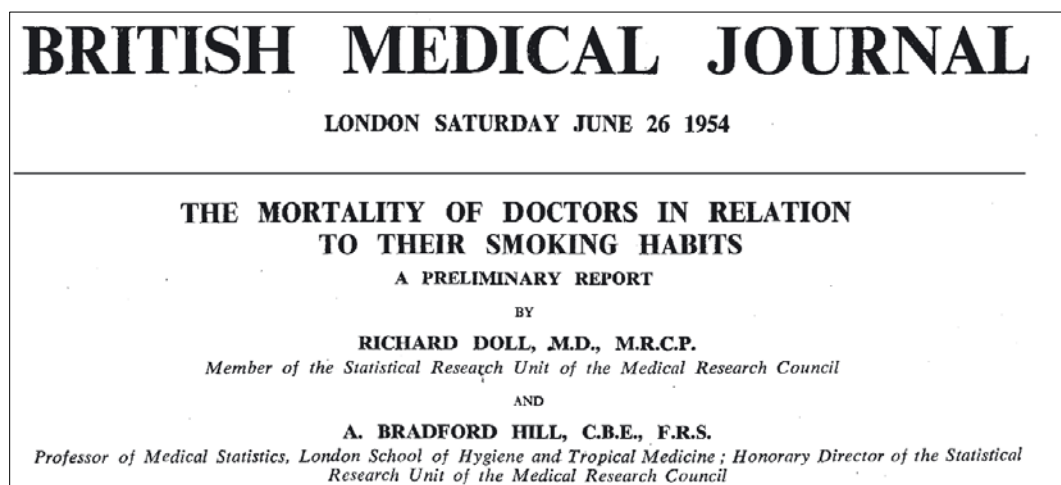
- Our international effort to develop an HIV vaccine is likely to show a very large return on investment [slide 12]. My colleagues Dean Jamison and Rob Hecht showed that every \$1 invested in this vaccine would return between \$2 and \$67, assuming a vaccine of 50 percent efficacy becomes available by 2030 and R&D costs of about \$900 million annually. Other game-changing innovations—like a single-dose malaria cure or inhaled oxytocin to treat life-threatening maternal bleeding—are likely to bring similar economic returns.



[slide 12]

- The examples that I have given so far have focused on developing new health technologies. But just as impressive are the returns to investing in population, policy, or implementation research, another global public good.

It was this kind of research, conducted by the British statisticians Richard Doll and Bradford Hill in the early 1950s, that was the first and most convincing evidence to show that cigarettes cause cancer. Doll and Hill, in their famous 1954 study of smoking among doctors [slide 13], published in the BMJ, showed that those who smoked 35 or more cigarettes per day increased their odds of dying from lung cancer by a factor of 40. At that time, 80% of British men were smokers.



[slide 13]

Doll and Hill's work on the health hazards of smoking is credited as being the main factor that drove an enormous fall in premature death in Britain and in many other parts of the world. The

awareness of the dangers of smoking has improved the health and life expectancy of countless millions of men and women.

The World Health Organization has set a target of reducing the global prevalence of smoking by one third by 2025 [slide 14]. If we can reach this target, we could avert about *200 million tobacco-attributable deaths over the course of the century*—both by helping current smokers to quit and by helping teenagers not to start.



[slide 14]

These are just a few illustrations of essential kinds of public investments.

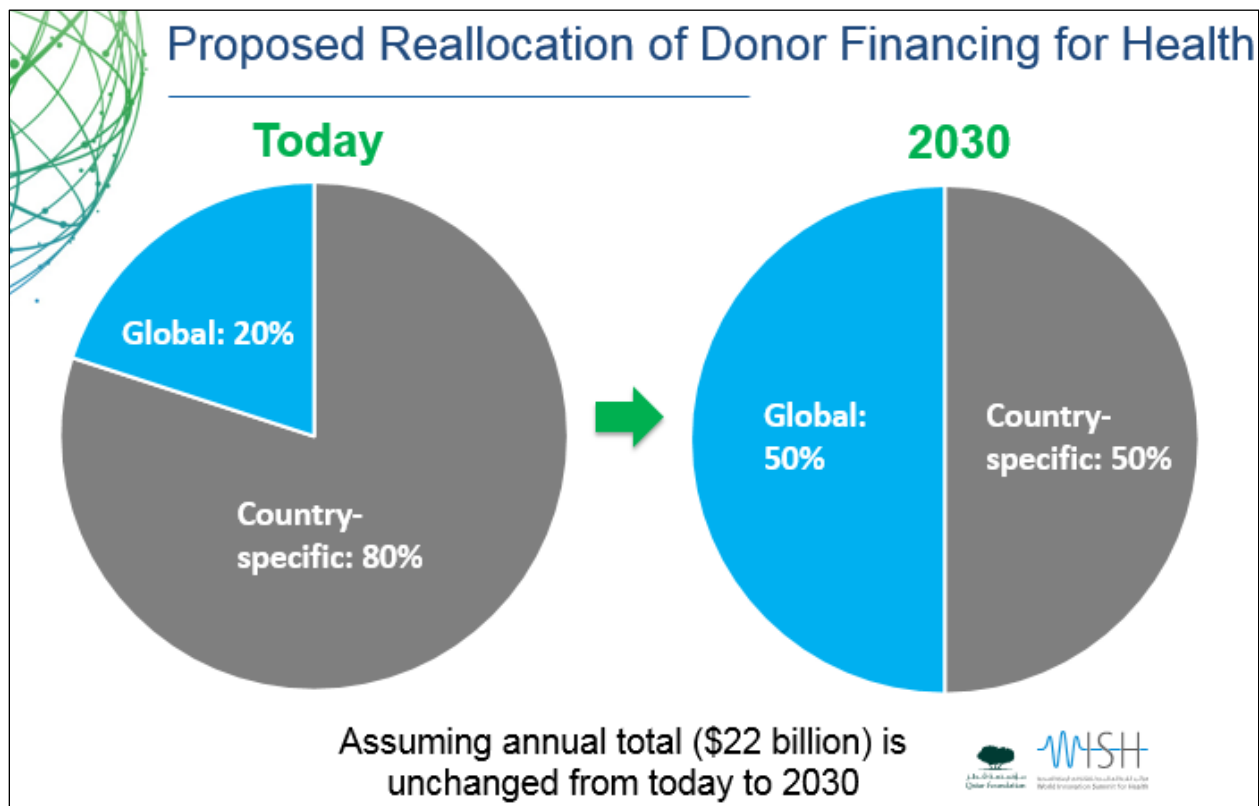
Where these arguments lead | reallocation of aid

In light of these three arguments—the superiority of domestic health investments over aid, the anticipated economic growth of low- and middle-income countries that will “free up” health aid, and the impressive returns on investing in global functions—I believe the world’s current allocation of health aid must change.

It must evolve substantially, and reasonably quickly, to support the global public goods agenda and other global functions. I think it would be a reasonable assumption to say that there is a need

for roughly \$11 billion annually of *extremely high priority* aid for global functions. If global health assistance remains constant this will require that the proportion of donor financing directed at global functions could increase from the current 20% to 50% by 2030 [slide 15]. In other words, by 2030, half of all aid for health would be for global functions and half for country-specific functions.

Of course if the envelope expands the proportion might be a bit lower than 50 percent and if it contracts it might be a bit higher.



[slide 15]

Conclusion | we need to drive this change

The lack of investment in this global goods agenda is an international emergency.

I have already spoken of the proven benefits of research. There is more.

The next Ebola is probably just around the corner. The next flu pandemic could well be far deadlier than the 1918 epidemic that killed 50 million people in the era before mass international transit. Indeed Dean Jamison and I have concluded in a recent study that the expected present value of the costs of future pandemics is in the same range as the present value of the costs of global climate change even though pandemics get much less attention as a problem.

There are those who believe that AMR--anti-microbial resistance is an even larger issue than pandemics.

I have become convinced that the obesity issue today is where the tobacco issue was 50 years ago with scientific awareness of an immense public health issue just beginning to be translated into policy action and with huge needs for investment at the global level if the benefits of greater understanding are going to be realized.

New global issues will surely arise. So we need to drive a shift in how we spend our aid dollars. This will be a challenge to the community because it represents a new way of doing business.

The stakes are unbelievably high.

We may worry about reallocations in our own personal savings portfolios—but here we're talking about millions of lives being on the line.

Tomorrow, here in Doha, with the kind support of the Qatar Foundation and the Bill & Melinda Gates Foundation, I will chair the kick-off meeting of a new year-long working group, focused on international collective action for health. We are aiming to develop an analytically grounded agenda for global health investments that can command consensus across a broad community.

CONCLUSION

A final thought. I have emphasized the desirability of a reallocation of health aid from support for service delivery towards global public goods and global functions not merely advocated increased financing for global investments.

This is a conscious choice. There is the moral point that I feel deeply as an economist--precisely because health is so important – that it is essential that rigor be brought to investment choices. There is a practical point as well. I found that as Secretary of Treasury I had far more time for those who did not just seek more resources for new priorities but were willing to contemplate ways of making do with less over time for existing priorities than for those just wanted more.

And it is essential those fighting for global investment be heard. Tens of millions of lives are at stake.