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TRANSCRIPT

Event

"The CommonHealth Live! on Financing Global Health in 2025"

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FEATURING

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CSIS EXPERTS

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Stephanie Psaki: Good morning. I'm Stephanie Psaki, senior adviser with the CSIS Global Health Policy Center and senior fellow at the Brown University School of Public Health.

Today on The CommonHealth Live! we are joined by Christopher Murray, director of the Institute for Health Metrics and Evaluation, to discuss the future of global health financing.

(Music plays.)

J. Stephen Morrison: This is the CommonHealth Podcast, a product of the CSIS Bipartisan Alliance for Global Health Security. We engage with diverse leaders on the question of how best to navigate this period of exceptional turmoil, reform, and uncertainty in U.S. leadership.

(Music ends.)

Dr. Psaki: Chris, welcome.

Today we are delighted to have the chance to speak with you and learn about the latest great work from your team at IHME.

I want to start by saying that I am a big fan of the Institute for Health Metrics and Evaluation. I have been for a long time, and as someone who has worked and a researcher in the global health field and a policy maker on global health policy I have found the work that you and your team do to be incredibly informative, useful, and really helpful in pushing us to look at the big picture at what is causing people to die, what is causing people to be sick, and how we can best direct our efforts and our resources to make sure that we improve lives for people around the world and for people, of course, in the United States.

So I'm looking forward to learning more today about your latest estimates on Development Assistance for Health, or DAH as we might reference it, and I think about that as the money that is available from all major sources so donor countries, also philanthropies, multilateral development banks, national budgets, and others to improve health for people around the world.

So let me start by just turning to you for an overview of the work that your team has been doing and then we'll have some time to discuss. Over to you, Chris.

Christopher Murray: Thanks, Stephanie, and thank you for those kind words about what we do at IHME. It's great to hear that it's useful, at least to some.

So since IHME started in 2007 one of our signature analytic efforts has been tracking global health finance so we have continued that tradition and released "Financing Global Health 2025" and it's also being – gone through the peer review process and published in The Lancet last month as well.

This year it's particularly interesting because of the cuts that have been occurring around the – in the U.S. but some other Western governments, as we'll see, and it's

particularly challenging. So the team that works on this led by Angela Apeagyei is – struggled a bit to keep up with the politics of the moment and so that's a caveat as we think about what's happening.

So let me start with sort of the headline finding, if we can, which is we produce this graph on – every time we do this report, which is in current dollars so – or 2023 dollars, to be precise. So the time series going back in time gets modified to reflect inflation.

And so this is in real terms now, real 2023 dollars, and it just tracks from 1990 to 2025, which is an estimate, what's happened to development assistance for health, and there was this big scale up during the – you know, the period when things like GAVI, Global Fund, PEPFAR were being created, and we got up to a level of around about $50 billion per year and that was pretty constant for about seven or eight years.

Then there's a big surge due to COVID funding and we get up to about $80 billion, and since the peak of 2021 money's been going down predictably because COVID funding has gone down as the pandemic has faded.

But then we see in – we got back to about the same $50 billion a year but we've seen this 22 percent, we think, drop from 2024 to 2025 and you can sort of trace this out in detail, which I won't go through. But, you know, the brown in the middle set of figures there is the U.S. So a lot of that drop is the U.S. drop but not just the U.S. The U.K. down close to 40 percent, France down, Germany down as well.

So there is a contraction, essentially, of commitment from many Western democracies for global health funding, and then it would translate in terms of the way the money goes to the world as you see in the bottom chart.

Now, a little bit more detail of seeing the country-specific drops on the bottom right here. If we zoom in the U.S., you know, there's this rather precipitous drop. This is unclear whether what will actually turn out to be the U.S. numbers because, as anyone who's been tracking the discussions on Capitol Hill, we're not sure what will be the 2025 numbers. But this is our best assessment at present. Now, we will keep these numbers up to date and live, and so if you're interested in what is our current assessment even beyond the report at healthdata.org you'll be able to see how we track those changes essentially in real time.

Big question is, you know, money's down; 22 percent drop in a single year. Maybe a bigger effect than you might expect from 22 percent because it's concentrated in the areas that the U.S. has traditionally funded like IHME, TB, malaria, and so that's part of the effect that may be a bigger effect than just 22 percent.

But perhaps the most important issue is shown here, that total spending on health, what does the cuts translate into in this one year? Well, they're not uniformly distributed around the world. It is the countries like Mozambique, or Zambia, or Malawi, or Somalia, where you've had greater than 15 percent cuts in total health spending. So the – even though it's a 6 percent cut for all low- and middle-income countries – or, all low-income countries combined, some places it's a really abrupt

and major contraction. And so that's where we expect to see the biggest consequences as we look ahead.

Now, what's going to happen – and the report also tries to anticipate what's going to happen. Again, will we see the sort of declines continue dropping? Our best guess is no; it'll probably stabilize at $36 billion a year, something like that, although I think there's a real concern among some that there may be contagion – that, you know, because of this sort of declining commitment, because of other reasons we can discuss later, maybe it can get even worse than what we're saying – or it can turn out to be slightly better. But either way, we expect there to be no large bounce back in the coming five years or beyond.

So those are our main findings in the report, and look forward to having a(n) interesting discussion.

Dr. Psaki: Great. Well, thank you again to you and your team. I can only imagine the amount of work that goes into producing these beautiful graphics that we all get to enjoy.

Let me start with, I think, the question that would come from many people in Washington on all sides of this conversation right now, which is: Are these cuts catastrophic, or are they kind of what we would expect in normal fluctuations as things change in the system? And that's maybe an unfair choice to have to make; your answer might be something in between. But I think there is a strong sense from many who are in the global health space that the dissolution of USAID, the very large cuts in foreign aid from the U.S. government, and some of the other cuts that you've referenced are catastrophic. And there was, as I'm sure you know, a paper published in The Lancet recently that estimated about 14 million additional deaths by 2030 due to these cuts.

When I look at the figures that you're sharing, of course it's bigger cuts than maybe we would have anticipated six months ago but it doesn't look like the entire system has been decimated. So how are you thinking about this? Is it catastrophic for the system? Is it normal fluctuations? Are you optimistic about the system being able to bounce back and recover?

Dr. Murray: Let's unpack that a bit because there's a lot in what you're asking.

Is it normal fluctuation? Well, no, because we had a – despite, you know, some donors up, some donors down year by year, the numbers somehow came out very stable for at least pretty much a decade pre-COVID, at about $50 billion a year. So countries counted on those funds. Institutions developed. You have this complicated story where quite a lot of the money was flowing through NGOs and almost a parallel delivery system in some countries for certain programs, so that governments weren't sort of co-managing the resources. So when suddenly those institutions stop, you get some pretty abrupt changes. So not normal fluctuation.

How will countries manage? Well, if you're India or, you know, a country in this region, very, very small effects. There may be some disruption of services because specific programs were funded by USAID, for example, and that may take a while to respond. But the development assistance for health is such a small percent that

those countries should be able to manage. The issue is, you know, basically, sub-Saharan Africa and maybe Haiti as another example, where, you know, the money matters – you know, it's 10 percent, 15 percent of total health expenditure for at least 10 countries, and in those places it will be hard. You know, there's all sorts of discussion about this is the moment for those countries to step up and fund their own programs, and we can explore that a little bit, but I think it will be challenging to replace those funds.

So I think we will see real service disruption. It will have real health consequences, particularly in those 10, 15 countries that are all low-income, where they were heavily, heavily dependent – at least the government side of service delivery – on those funds continuing as they had in the past.

Dr. Psaki: Yeah. I think – I mean, you touched – I think you mentioned the abrupt changes, and I think it is important to separate out two issues. One is how abrupt the changes were and the other is how much funding there will be available going forward.

You started talking about domestic resources, and that's where I wanted to go next. So, you are probably aware that yesterday African leaders met in Accra to discuss health sovereignty and domestic financing for health, and, you know, this exact question about whether and how to fill some of the gaps that are left by these disruptions in outside financing. But Africa CDC and others have pointed out that few African countries have met the target set out in the Abuja Declaration of spending 15 percent of national budgets on health, and I think Africa CDC and other African leaders are really pushing countries to get closer to that target.

I think the point that you're making about some countries having been more dependent on this outside aid than others is a really important one. Some might look at multilateral development banks as potentially filling those gaps, but that funding is already incorporated into your models.

So I think the big question then is, if we look at those 10 or 15 countries that got the largest proportion of their budget from outside funding, where is that going to come from? Who can fill the gaps? Can it come from domestic resources? Can it come from regional sources? Can it come from the private sector, which I think is a partner that I've heard mentioned frequently without a lot of specificity on what that looks like.

So how are you thinking about what a model might look like to try to fill those gaps long-term, but also kind of in the interim to get those countries on more stable footing?

Dr. Murray: Well, first off – just start with the data and what we see empirically, and then let's move on to what might be the path out of the situation.

So empirically, you know, there's long been this question about sort of crowding out – when development assistance comes in, what administrators of finance do? And then when the money goes away, is there compensatory spending, right? Do ministries of finance go back and fund those programs?

And so on the crowding-out side, there is quite a lot of crowding out empirically, from the literature that's out there. And more disappointingly, even before debt servicing going up, because interest rates have gone up, there's not a whole lot of evidence for compensatory spending.

Now, admittedly, those are econometric models being fit to relatively small changes, and so this huge change – at least in 10, 15 places – might have a different response. And you know, we've – some will have heard about Nigeria committing an extra $200 million for – to fill the $600 million gap left by USAID. So there may – there could be some examples of compensatory spending.

On average, though, the very-low-income countries that have the biggest dependence, the biggest reduction, have very little fiscal space to fill the gap. And so it seems like if there is some compensatory spending it will be quite small and not fill a lot of that gap. So then what do you do? I don't see how the private sector, given past, you know, patterns of, you know, where the money goes, is going to make a big difference.

When we look and try to disentangle, like, what are the actual effects on human health of the aid cuts, then you suddenly find out that there is enormous variability, even within low-income countries, of how efficient health systems are at producing health. So then you have to start saying, well, let's say there's some model where there will be less money overall. Maybe the development banks can prioritize these countries that are the most affected. Maybe there's some compensatory spend. But maybe there can also be part of that story trying to understand why there is really large differences in price per patient on HIV, price per child vaccinated, and just general health system performance across quite similar countries.

So I think the future has to be some mixture of trying to tackle those. But I wouldn't – I don't see any sort of silver bullet from some other group stepping up and filling the funding gap.

Dr. Psaki: Yeah.

So you've started to touch on this, and you know, I mentioned in my opening remarks how incredibly valuable some of the other areas of work that IHME does have been, including the Global Burden of Disease work and just understanding this big picture of what are people dying from, what is making people sick. So if we think about pairing that picture of where are the health needs with where is the funding and where are the funding cuts, what do you see in terms of the biggest concerning gaps that are emerging both from these cuts but maybe also from areas that were insufficiently funded prior to these gaps?

Dr. Murray: So the answer to the latter part – like, where does the money go, where is the need – depends a lot about where you're looking, right? Because if we look at even just the sort of basic demographic trends, sub-Saharan African countries – excluding South Africa and Botswana, who are sort of, you know, very much better in terms of economy and health outcomes – looks very different than, let's say, South Asia. So if you look at a measure like child mortality, you know, there's a lot of child mortality in the world, is still in South Asia the majority and sub-Saharan Africa. But if you

look at the prospects or the gap, India is in this rapid demographic and epidemiological transition. Urban India starts to have, you know, a big burden of noncommunicable diseases. Their fertility rate's below replacement now – so, you know, below 2.1 children per woman on average. Very different than, let's say, the Sahel, where you still have high fertility, super high poverty, very much a burden of disease dominated by infections in children and things like TB and HIV. So the needs gap is quite a bit different in South Asia, you know, sub-Saharan Africa, and then the poorer parts of – or, middle-income parts of Latin America.

What will the affects – we're very, like everybody, wondering what will – will this incredible success story we've been living through, where, let's say, child deaths just keep going down every year since, you know, as long as we have data, at least back into the '80s, is that going to continue? And probably not, or at least the trend down will look pretty different, we suspect. But answering that question means you are trying to come up with an answer as to what do you get for every dollar that you spend on a health system.

And that ties back to what we were talking about before, which is you get a lot more in some countries – let's say Niger, where for whatever reason money has translated into child death reduction in a very efficient way, probably because most of it's gone to prevent, to vaccination, programs like that – as opposed to some other countries that are equally low income where it's not being so efficient. So we have to answer this age-old question of what actually is the return on investment.

And then the way we try to do that, we try to take the data on, let's say, child death or HIV or TB, look at the relationship – first, remove how much of that pattern is explained by risk factors that are not specifically related to the program; so remove things like obesity and environmental – you know, air pollution. And so you can risk-adjust those numbers using all the GBD data we've been talking about. And then you look at that relationship versus total health spending, and then you can – what in economics we call sort of a production possibilities frontier, and figure out who's most efficient. And when you're on the efficiency frontier, what do you get for your investment? And then, where do people stand?

You do all that, put it all together, and depending on how you – what you do or do not control for we expect, you know, somewhere between 2 ½, 3 million extra child deaths between now and 2030. So, you know, that's quite substantial. You will – that'll translate into changing the trendline, but not necessarily going up by 2030 but just lowering the progress we would have expected. So, you know, our many-decades run of net steady progress is going to probably look different in the next five years.

Dr. Psaki: Yeah.

I'm struck, as you're talking about – now, you – now, you mentioned earlier that when we look at the patterns of cuts to different diseases we see a pretty large cut to HIV/AIDS spending because it's an area where the U.S. government has played such a leadership role through PEPFAR and support for The Global Fund. And as you're describing, you know, what we can do in terms of saving lives with money, I think it's impossible not to think about lenacapavir, which is this incredible

breakthrough prevention technology that is just now available. And I know that the planning before these cuts had taken place was really based on an assumption that PEPFAR would still be operating at scale and Global Fund would be operating at scale, and Gilead was anticipating that in terms of the rollout of this product. Do you think that – you know, hopefully, PEPFAR will still be maintained at some level – as we think about technologies being introduced – whether it's that one, a new TB vaccine hopefully in the coming years, others – it could potentially compensate for the lost funding in terms of more efficient ways to save lives?

Dr. Murray: We have a lot of innovation, you know, coming, as you've mentioned – some already in hand, lenacapavir. Usually when new technologies come along it requires some push to get them out. It actually usually requires more money, not less, initially, right? And then eventually you get it – you know, for example, if we're able to prevent a large fraction of new infections for HIV, that translates into real savings in the future. But that first push requires funds, or at least historically has. So I don't know if the reduced funding will be solved at least in the next three, four, five years by the technical innovation.

What it will do is trigger a very serious discussion about priority setting, right? If you're Global Fund, maybe all the resources should be focused on low-income countries and not distributing some of them across middle-income countries. And then that might create the space to deliver some of these innovations that are, as you mentioned, not just TB and HIV but innovations coming for malaria, for some, you know, new vaccines for children. So there's a lot in the innovation pipeline that should be funded and will have big impact. But these cuts likely will make it slower to roll out new technologies.

Dr. Psaki: I'm just struck, you know, hearing you talk about this and thinking about the efficiency in how the resources are spent that often we do, I think, as a field look very much at the amount of money going out there and not nearly enough at how that money is being spent and how it's translating into lives saved. And even as we evaluate the roles that different donors play in this space, thinking about how different donor dollars are efficiently used to save lives I think is a really important, increasingly important part of the conversation. So I'm glad you made that point.

If we can just spend another few minutes on the Global Burden of Disease question and think about this demographic change that you mentioned that we're seeing now in many lower-middle-income countries/middle-income countries but will increasingly see in low-income countries toward noncommunicable diseases, which traditionally have not been a big area of focus in donor funding, as we think about – you know, we're in this changing moment in the entire field. As we think about what the future can and should look like, how should we think about incorporating the changing burden of disease into the sources of funding, but also what the funding is focusing on rather than being these disease-specific programs?

Dr. Murray: So, I mean, to try to answer that question, and help governments and other actors and, you know, foundations and others think about where they can have the biggest impact, we have quite a – built up now quite an elaborate forecasting program. So we have the Burden of Disease; you know, there's 16,000 people around the world who work on it, and a couple hundred sitting in Seattle who are helping coordinate

it. But now we've – building up the forecasting element to do two things. One is try to say what's most likely to occur; so, you know, capture those demographic changes, capture – as countries transition to middle income, you know, their profiles really change pretty fast. And then capture the fact that, you know, Africa really grows the most, and so even if we're making progress in a disease like malaria we should expect malaria deaths to go up because more and more of the world's population are in Africa.

So that forecasting program we also run a bunch of scenarios – you know, what if you addressed smoking and what if you did a better job on some of the key behavioral risks around, let's say, diet and physical activity, and because there's a lot of risks in the GBD and there's a lot of other interventions you can ask a lot of these sort of what if questions.

So bottom line is the answer is different by place, as you might guess. At the macro level, you know, the world becomes more African over time because of just population growth, and they also don't have a lot of economic growth compared to other regions in the past 75 years and the econometric type scenarios suggest they will lag behind other parts of the world in the next, you know, 25 years.

And so we still – we expect, for example, the number of people in absolute poverty in Africa will not go down out to mid-century. That matters hugely for global health, right, because it means that the traditional focus on infectious disease and diseases of children will remain probably the key issue in sub-Saharan Africa, whereas everywhere else in the world it'll rapidly shift towards the NCD challenge.

Dr. Psaki: Yeah. And, of course, you know, within regions and countries you will have different people who are facing the same diseases and multiple diseases at the same time. It's interesting to just think about, you know, both the needs globally of different regions and different income groups of countries but also the role as donors of different types of countries as they go through that evolution.

You know, we have often focused pretty narrowly, I think, on what we think about as the G-7 countries as major donors and have – you know, this set of countries has been the largest donors, as you show, for a long time. But I think there is a question, and you touch on this in your analyses, too, about other countries emerging as contributors to the system and what that looks like.

So I wonder about your thoughts on other countries that are kind of outside of this G-7 group that have been emerging as donors in the system and what you see those roles looking like in the future. You know, will it be sort of new donors who contribute to the Global Fund and kind of the model that we've been using or will it be, you know, bilateral investments or some other form?

Dr. Murphy: So this round we put quite a bit of effort, or the team did, I should say, into trying to get the best you can on China, UAE, Saudi Arabia. We looked at the spending from Turkey and some of the non-G-7 European governments as well and, you know, places we've already captured like Australia and New Zealand.

So definitely trying to capture new donors as they emerge. Those new donors add up to, you know, really a relatively small percent right now. You know, we're in the 2 (percent), 3 percent margin.

Now, they might grow. Obviously, China is the one that people would hope would fill the gap. I'm not sure they will. And so important to keep track of will there be new donors, hopefully – will they choose multilateral mechanisms or bilateral. I think this is the contagion question that we're – we and everybody else is so worried about.

Will the sort of lack of faith from the U.S. in the effectiveness of multilateral institutions lead to the drive to 5 percent of GDP in Europe for defense and, you know, using development assistance money in a country like the U.K. to deal with refugees, all of which will eat away from, perhaps, money going to the multilateral funds and institutions.

Dr. Psaki: Yeah.

I know that the Gates Foundation is one of the donors that has supported this work, maybe exclusively supported this work – I don't know – and you include the contributions of the Gates Foundation as well as other philanthropies. You know, I think there are a lot of questions out there especially with the announcements from Bill Gates about the push from the foundation in the next couple decades about what their role might be to fill the gaps.

I'm not going to ask you what their role might be but I am curious about what you see as the role that philanthropy should play in general in this moment. I think what I have heard from different philanthropies is that they don't see themselves as filling in the role that governments should be playing. They see themselves ideally as catalyzing change, catalyzing investments, and supporting transformation. But do you see sort of an area right now where they could be most helpful in this transition to whatever comes next?

Dr. Murray: So I think the traditional long-running philanthropies whose assets are not going to suddenly balloon can't fill the gap, right. They have very expected revenue from their endowments. We have the Gates Foundation where Bill has – Gates has committed to spending it down so he's going to maintain in real terms the 9 billion (dollars) that they spend as a foundation of which, you know, almost 6 billion (dollars) goes towards health.

So that's great for health. But I think the real question on philanthropy is there is a tremendous amount of wealth in other very rich individuals that are in the top 10 lists, some of whom are – you know, many of whom are based in the U.S. and in many cases have yet to pick a cause that they may use their wealth to address.

So I think there's potential there. It's part of the – making the case, especially because of some of the technical innovation, that there are these incredible opportunities in global health that would benefit – where they could feel confident that their resources would be impactful.

So I think there's an opportunity there building on what is really quite extraordinary assets that have grown of late. The others – you know, the other thing is how will some of the very things that have created such wealth like AI, how will that translate into maybe getting more done with existing resources.

Dr. Psaki: Yeah. You know, there has just – continuing with this theme of this evolution that is happening whether we like it or not but using the opportunity to envision what the future might look like, there's been this focus, I think, with a lot of bilateral funding historically on these disease-specific programs that are concentrated in a country and, you know, ideally working with the ministry of health in that country, and less of a focus on what many call global public goods or sort of, you know, regional – small regional, big regional global efforts and investments that might have broader benefits but also really require collaboration and a shared vision.

There's a lot of discussion about – in the global health security space about surveillance and establishing better surveillance systems, about diversifying manufacturing medicines so that they are not all concentrated in high income countries, about having a global health emergency force that can be deployed to different settings.

I'm just curious about your thoughts, again, as we dream about what the future could look like and needs to look like in order to address these health issues. What are some of those regional or global investments that really could be well spent in terms of lives saved and also address some of these largest burdens of disease?

Dr. Murray: So a super interesting question. I mean, we tend to – we like to believe that we're in the business, as many groups are, in creating global public goods like around the information/data side. So that's how we sort of describe ourselves to ourselves.

The GBD is an example of global public goods just as this report on financing global health is but there are others, of course, right, and surveillance is a great one.

Now, the way I tend to try to think about that question is to step one step back and say what are the biggest threats/opportunities for health coming, and I actually co-chair with Natalia Kanem, who used to be the head of UNFPA, a Lancet Commission on 21st-Century Global Threats to Health.

So very explicitly can you step back and say what are the biggest challenges – you know, pandemics, climate – you know, and opportunities, doing something about obesity and diet and physical activity, nuclear war, AI, et cetera.

So there's about 20 threats we've looked at and that work is not yet finalized, but the idea is to try to say what are the big problems that aren't part and parcel of sort of routine health system service delivery and what do you do about those. And so, you know, information and knowledge about what are potential threats is a – for health and for national security, is clearly one of those. Innovation – you know, new innovations, new drugs, new vaccines, new procedures, even innovations around climate changes are things that are consequential for health.

So I think those are global and/or regional public goods that matter a lot. Are we seeing much progress on that? No, not really. Right? We're not really – we did a lot during COVID of trying to follow what was happening in the epidemic. Are we in a better position today? I'm not sure we are. I don't know – I don't know if the world has internalized the need for that sort of regional-national-global public good.

Dr. Psaki: Well, that's so exciting to hear about the work that you're doing with Natalia Kanem and looking forward to that coming out because I do think having a shared vision of what are these biggest threats that we can work toward could be helpful. And when we're talking about something like global public goods, especially the ones that intersect with national security, I think it is easier to make an argument even to leadership in different countries that might be less supportive of a traditional development assistance lens that they should be investing resources not just from ODA funding but also from development and national security funding into those global public goods. So that seems like a hopeful area to keep thinking about in the future.

So I want to talk a little bit more. You've touched on innovation, and we talked about lenacapavir and a couple other innovations in the pipeline. You mentioned AI. And just think a bit about how that also can be an opportunity to transform these spaces we're in with this changing moment.

On AI, I think we hear a lot – and maybe this is just the conversations that I sit in – about the threats of AI and the risks of AI in terms of national security and in terms of health. But we also, you know, touch on the opportunity and the promise of AI and I'm curious about how you're thinking about the promise of AI for the global health field broadly, but would love to also hear about how it's going to affect the work that IHME is doing.

Dr. Murray: Yeah. I think it is the – you know, we're living – on the global health front there's two incredible sets of changes, the transformation around finance or the reduction and then what will be the effects of AI maybe not from what we currently have in hand but what we might expect to have in two or three years. But even with current, you know, foundation models and then the right sort of applications built on them there's a very real prospect that you could deliver to a rural clinic in a low resource setting pretty high-end diagnostic abilities.

Now, whether you have all the other bits necessary in place to deliver the care that people would get but at least on terms of clinical management, guidance, and diagnostics or, you know, differential diagnosis we should expect that that will come, right? So I think that can make a pretty big difference in terms of the quality of care that you can get as – you know, increasing access to that sort of quality of care. You know, lots of steps have to happen in between but that seems a very real prospect.

We will probably see the business of surveillance, global public good generation made quite a bit more efficient through AI and if the trends continue – you know, of any of the more optimistic views of, you know, AGI in the next five years you have a very different view of how a health system would function and design.

You will in any future like that be very data hungry. Like, you know, these models – these systems will perform well as long as there's lots of data that's available. So the business of getting high-quality data, curating it, will still matter or maybe matter even more. But I do think we should expect the process of producing health will transform quite a lot.

Dr. Psaki: And so I think you're alluding to it but how do you see AI changing the work that IHME is doing? I hope that we still are getting these valuable products. Maybe you can get them – you can produce them much more efficiently and then produce many other things as well. Is that how you're thinking about it or what's the future?

Dr. Muray: Yeah. I mean, that's our hope, that some of the very labor-intensive, critical steps like systematic reviews – you know, I think for each cycle of the GBD, in principle there's about 1,200 systematic reviews we should be doing. We don't have the resources to do that, so we have some cycle where we – you know, the critical ones we update every cycle, but some maybe every five or six years to see what new literature goes into a particular area. If you're a physician, you know, you should have available up to today the systematic review about what drugs and interventions or procedures, and so that's just produced routinely as opposed to needing some group of academics to sponsor a systematic review and then go through it and publish it.

So that'll transform the very labor-intensive parts, but it does mean we should be able to be more up to date on – with what we deliver to the world. And I do think it opens up the possibility for us to do more of that what-if type scenario building, which is what we constantly are asked by policymakers to answer. Like, if I – if I spend money on X or Y, what will be the consequences? So I see us able to, you know, answer more of that demand if and when we're able to get the basics around, like, the GBD made more efficient.

Dr. Psaki: OK.

So one more – one more question from me and then I'm going to see if there's anything else that you want to touch on in the report or otherwise that we haven't talked about. But this is just kind of a personal interest of mine, which is, having worked both as a researcher and a policymaker I continue to be dismayed at the disconnect between those two worlds even with the best of intentions. And I'm curious, because the work that you have done is so focused on informing policymakers, and I think often, you know, producing results that say pretty clearly here's where the money should go and that's not always where the money should go.

So what do you think from the work that you've done researchers or people on kind of the data side can do better and more effectively to communicate in ways that will inform the decisions that policymakers are making? And what do you think on the policymaker side can be done more effectively to integrate the data and the evidence into policymaking? And I think, you know, if we takes as a given that you have policymakers who want to integrate data and evidence, which I think many do, how can that be done better and more effectively on both sides?

Dr. Murray: You know, one thing as, you know, a manager of people that we all learn is that you can't get everybody to be equally skilled at all tasks, right? So, you know, the idea that we're going to have 500 people at IHME all of whom can do every task equally well, that's not how organizations work.

Likewise, we shouldn't really expect that the same skillset – you know, curiosity, analytic ability – that leads to a good researcher will mean that they're a good communicator, because that isn't the case, right? There are – there are, you know, extraordinary people who excel in both, but it's not the norm. And I don't think we should think that it's the norm.

So then it's about the institutions/mechanisms whereby some signal is sent to the researchers that these are the priorities that society and political leaders representing society want answered, and incentives so that they try to answer those questions – which is not the case right now in many spaces. And then, you know, how does somebody take the results that are in the literature that are not meant for decision-makers, and then deliver it and translate it, you know, institutions – we're sitting in one that tries to do that, at CSIS?

And so I don't think we're going to retrain researchers to suddenly all do that. And so – and we shouldn't try. We should let them do their – what they do well and think about the ways that you deliver that information.

Right now my concern is that a lot of – as you would guess in a democratic and even not-so-democratic society, a lot of decision-makers are heavily influenced by the media. And the media's sophistication around thinking about health issues I think has gone down over the last decade, not up, partly because, you know, there's fewer journalists out there specialized. And so that's a challenge, right? You get equal coverage in the media of something in some very – you know, not a great study to things that are sort of more thoughtful and well done. And so just how to – how to think about influencing what gets the attention of decision-makers, which I don't put the onus on the researchers but we should think about how that happens.

Ms. Psaki: Yeah. Yeah, and the media in the traditional sense and then the many other sources of information that are out there, and thinking about how to make sure that accurate information is being disseminated I think is a real challenge facing the public-health field broadly.

OK. So I wanted to wrap us up with just what I'm taking as some themes from this conversation. But before I do that, let me ask you if there's anything that you wanted to touch on from the report or your work that we haven't had a chance to cover.

Dr. Murray: You know, the thing that I take from the sort of global health shock that we're going through in terms of the financing shock, that a rising tide, you know, floats all boats; there was very little discussion in global health about why there's so much variability in the cost of different services and programs. You know, if you look at even something like family planning, the cost for a year of protection for a woman, you know, 10-, 20-fold variation across low-income countries. And wherever we look, we see the same thing. And nobody really wanted to talk about that because there was a fear that if you said some people were more efficient than others that

might somehow start to unravel the political consensus that these programs should be funded.

But when money is scarce, we need to really dig into that and figure out why and how you move countries towards being more efficient, while at the same time reaffirming what we know is empirically true that the returns, even amongst the less efficient, are still pretty impressive. You're still getting a lot for the investment. But we can't just sort of ignore the sort of variability in health-system efficiency, and we should try to learn those lessons. So that's the one that I'm waiting to see a bigger engagement from academia, from various groups as to sort of answering the why are some programs more efficient than others.

Dr. Psaki: Yeah. Great question.

OK. Well, thank you so much for this conversation. Let me try to wrap up and you tell me if there's anything I missed or anything you want to add.

So I encourage everyone to take a look at the paper and the report once the paper is published, but I think my takeaway here is that, yes, this is a pretty substantial drop in terms of the money that is available for health globally but the effects of the drop are probably going to be most felt in the countries that were most dependent on foreign aid or external funding for their health systems. And that's a handful of about 10, 15 countries, mostly in sub-Saharan Africa, and you mentioned Haiti, I think.

And given the fact that we are in this moment of reduced resources, whether we want to be here or not there are some really important questions that it's time to revisit about the efficiencies of how those resources are spent.

And also, this opportunity of new technologies, new innovations being introduced that can maybe help us to drive some efficiencies to make sure that the resources that are out there are being spent effectively even as we encourage some others to come into the mix and fill those gaps.

And some others who we discussed potentially coming into the mix are some private individuals who have made a lot of – have a lot of money, have a lot of resources, but have not come into the philanthropy space yet. So there's an opportunity there as well as, of course, the philanthropies that exist. There are middle-income countries – newly middle-income countries or middle-income countries for a while – who are increasingly playing a role that could perhaps play a bigger role. And of course, a lot of questions about whether there will be this contagion effect from the U.S. cuts to other donors who have been big players in this space for a while.

We talked about the demographic changes that are happening now around the world and vary by region. And you said that while you expect that infectious diseases will still be the largest cause of death in sub-Saharan Africa for a while, in other regions we're seeing an increasingly relevant role for noncommunicable diseases or chronic diseases. So thinking about what type of financing and innovation is needed globally with that pattern changing I think is really important.

And then we talked a bit about just really interesting work that you're doing on – with Natalia Kanem on understanding the biggest threats from a global-health perspective but also thinking about the biggest opportunities in terms of global public goods – where can we really push innovation, again, but thinking about regional goods or global goods that can get buy-in from that global system in a way that really drives progress for everyone and doesn't feel like a zero-sum game the way that perhaps the development system has felt for a while.

Is there anything important that I missed in terms of the themes that we touched on?

Dr. Murray: No. That was a great, great summary of –

Dr. Psaki: OK. (Laughs.) OK.

Dr. Murray: – a really interesting discussion.

Dr. Psaki: Well, thank you again, Chris. And I know that you have a big team behind you that puts a lot of work into producing these reports, so thank you to your incredible team. I hope they feel proud of what they've done here. I'm looking forward to seeing more of what comes from IHME in the future, and really appreciate your time.

Dr. Murray: Thank you.

(Music plays.)

(END.)