



Restructuring US Global Health Programs to Respond to New Challenges and Missed Opportunities

Amanda Glassman and Rachel Silverman

Introduction

In the absence of effective international institutions, the United States has become the world’s de facto first responder for global health crises such as HIV/AIDS and new threats like Ebola. The US government has the technical know-how, financial and logistical resources, and unparalleled political support to act quickly and save lives. Initiatives such as the President’s Emergency Plan for AIDS Relief (PEPFAR) and the President’s Malaria Initiative are widely considered among the most effective aid programs in the world.

Yet US global health approaches are based on increasingly outdated engagement models, which fail to reflect emerging challenges, threats, and financial constraints. Effective HIV/AIDS control efforts, which already cost US taxpayers many billions of dollars each year, will require more funding as a result of new science and ambitious program coverage goals.¹ At the same time, noncommunicable diseases—such as cancer, diabetes, and cardiovascular disease—have exploded in developing countries. Moreover, the United States and other donor countries historically have spent little on national health systems; in 2011, for example, just 4 percent of development assistance for health went to programs to strengthen health systems.² The inability of West African nations to combat the Ebola crisis demonstrates the practical impact of those past spending decisions, with frightening results in the United States and abroad.

The next US president, working closely with Congress, should modernize how US global health programs are organized, deployed, and overseen. By taking three specific steps, the United States can reduce the need for costly first responses and generate more health and economic impact for every US taxpayer dollar spent.

POLICY RECOMMENDATIONS

- Appoint US global health leadership with the mandate, budget alignment, and political support to enforce interagency collaboration.
- Harmonize the approach to multilateral organizations to ensure consistency of priorities and objectives.
- Establish an office of Global Health Trade, Economics, and Knowledge Exchange responsible for sharing US health-care know-how with policymakers and businesses in developing countries.

First, the new presidential administration should establish clear global health leadership with the mandate, political support, and accountability to implement coherent government-wide policies and enforce interagency collaboration. Second, the US government should drive reforms at related multilateral organizations, such as the World Health Organization (WHO), Gavi, and the Global Fund to Fight AIDS, Tuberculosis and Malaria. These reforms would ensure that technical excellence and programmatic outcomes are more effectively prioritized and rewarded. Finally, the US government should increase its partnership for sustainable health investment and collaboration. To do so, the next administration should establish a US Department of Health and Human Services (HHS) office focused on sharing US expertise in health-care development and management with developing-country policymakers.



New Global Health Threats amid Historic Progress Combatting Infectious Diseases and Child Mortality

Men, women, and children have better prospects today for long, healthy lives than at any other time in human history. In just the past two decades, deaths among children under five years old have dropped by almost half, from 12 million to less than 7 million each year.³ Moreover, these health outcomes have been shared broadly across socioeconomic groups within developing countries. In fact, life expectancy in many low-income countries has outpaced similar gains in high-income countries by a factor of two to one.³

At the same time, the economies of low- and middle-income countries (LICs and MICs) have grown dramatically, enabling them to double their own domestic health spending.⁴ Based on strong growth and income-based eligibility limits, many traditional aid recipients, such as Ghana and South Africa, are now ineligible for health assistance from many multilateral organizations. Many more will “graduate” from such aid over the coming years.

As infectious disease burdens have lessened, new challenges and opportunities have emerged. While US-supported HIV/AIDS programs have saved millions of lives, these efforts have essentially become an international entitlement that costs many billions of dollars per year. Because of new science, growing program coverage, and ambitious global goals, the fiscal requirements for HIV programs have grown even further in recent years. These requirements exceed the domestic financing capacity in many low- and middle-income countries,⁵ thereby threatening the sustainability of US investments made to date.

Cancer, cardiovascular disease, diabetes, and other noncommunicable diseases have meanwhile grown in importance. These diseases now kill more than eight million people in low- and middle-income countries each year, at younger ages and with worse outcomes than in wealthier nations.⁶ Emerging infectious threats, like Ebola and influenza, have resulted in large-scale outbreaks with global implications. Moreover, growing antimicrobial resistance threatens to erode or even reverse major health gains both at home and abroad. And the growing sophistication of health markets and systems has generated ever-growing demand for US pharmaceuticals, medical devices, and other health

products in low- and middle-income countries, as well as know-how and expertise on insurance, payment, and management of health systems, representing an unprecedented opportunity for US expertise and firms.

Outdated and Inefficient US Global Health Structures

Despite rapidly changing needs and priorities, the US government’s approach to global health has remained stuck in a previous era. Existing US global health infrastructure, established to address short-term emergency outbreaks and specific infectious diseases, cannot effectively respond to emerging challenges because of its lack of an overarching strategy; multiple and sometimes unfunded or conflicting mandates; fragmented leadership within the executive branch and at multilateral organizations; dispersed accountability for results; disease- and intervention-specific budget earmarks that can limit efficiency by forcing allocation to certain activities even when they may not produce the desired outcome; and insufficient or ineffective tools to secure greater health investments by developing countries. Put differently, US government mandates, budgets, and accountability structures currently are not aligned or deployed for maximum impact on US health, foreign policy, or national security objectives.

The US government ignores these challenges at its own peril. Infectious diseases are increasingly global and require modern and flexible responses to minimize health impacts and protect economic gains both at home and abroad. The recent Ebola outbreak in West Africa illustrates how rapidly an inadequate response can lead to unnecessary loss of life overseas—along with anxiety, economic impact, and electoral liabilities here at home.⁷ Ignoring such challenges also means missing opportunities to promote US diplomatic and security goals by increasing US leverage with developing-country governments.

Finally, adapting to these modern global health challenges is simply the right thing to do. Americans take tremendous pride in their generosity and impact on the lives of men, women, and children in developing countries. Roughly 84 percent of Americans believe that “improving health for people in developing countries” is a top or important priority for world affairs, and 61 percent either support current global health spending or believe it should be increased.⁸ The US government owes its taxpayers assurances that it is using health aid



dollars as effectively as possible to drive global health impact and to ensure that their own health is secure from global threats.

Fractured US Government Leadership and Policymaking

The troubles that plague US global health structures are longstanding and start with their institutional setup. Far from a unified approach with clear and coordinated goals, US global health programs are spread across eight executive branch departments, four independent or quasi-independent federal agencies, numerous departmental agencies and operating units, and at least four large-scale, multiagency initiatives.⁹ Within the executive branch, only the president has singular authority over all constituent parts of the apparatus, but because White House attention is limited, most US agencies typically run on autopilot until new crises arise.

Muddled policy at home creates missed opportunities to drive US policy priorities and reforms abroad. The US government is represented by different agencies at each of the major multilateral global health organizations, with little coordination across them. By illustration, HHS has the lead on WHO, USAID at Gavi, and PEPFAR at the Global Fund. This model contrasts sharply with US government approaches to other multilateral organizations. For instance, the US Treasury Department has the lead on the World Bank, the International Monetary Fund, and all regional development banks; that set-up has promoted system-wide reforms and best practices with good results.

The US government’s fractured representation at global health institutions has led to inconsistent policy priorities over time, with limited impact on much-needed governance reforms within these bodies. In one important exception, an interagency team led by the Office of the US Global AIDS Coordinator (OGAC) successfully pushed for important reforms at the Global Fund to Fight AIDS, Tuberculosis and Malaria—yet even there, some have noted that the consolidated voices of disease-specific vertical programs (e.g., OGAC and the President’s Malaria Initiative) may have crowded out the priorities of US tuberculosis programs, which lack their own dedicated institution.¹⁰

The lack of coherence partially stems from policy-level indecision about the overarching goal of US global health investments, that is, whether the US primarily aims to save lives overseas or to foster long-term

systems development by supporting more effective policy development, service delivery, and financing arrangements. In principle, these are compatible and deeply connected goals. Yet balancing across these objectives, while also maintaining a consistent balance across agencies, has been problematic in practice. This tension begets fragmentation: the life-saving and development programs pursue parallel goals through parallel structures, creating chaos and confusion in the US policy arena and among all partners.

Fragmented Congressional Oversight Responsibilities

Congressional authority and oversight is similarly fragmented. There are two authorizing committees and two appropriating subcommittees in both chambers. Further, the US Senate Committee on Health, Education, Labor, and Pensions also has oversight given Centers for Disease Control and Prevention (CDC)’s involvement. This contributes to stovepiped and piecemeal strategies, ad hoc goal setting, and diluted accountability. Not only do US entities involved in global health have their own authorizing legislation, but they also have their own authorizing and oversight committees and frequently their own appropriations committee and federal budget account—sometimes even multiple committees and accounts for a single agency.¹¹ In addition, new or shifting priorities within Congress typically result in ever-growing cause-specific legislation and appropriations, feeding ever-increasing bureaucratic complexity.

Recent Reform Efforts Have Failed to Move beyond Rhetorical Change

The Obama administration acknowledged significant deficiencies in US global health efforts early on. In 2009, it announced plans to unify fragmented programs under a single umbrella; dismantle vertical structures in favor of an integrated approach; and transition narrow, disease-focused programs toward broader health challenges, such as maternal health, child survival, and health systems strengthening.

Yet its implementation, through the short-lived Global Health Initiative (GHI), was a poorly conceived exercise in aspirational rhetoric over substance that proved inadequate to address the core problems. First, the GHI could not consolidate budgetary and programmatic authority—and thus strategic planning and accountability—within a single leader or agency. Neither



USAID nor CDC had a clear comparative advantage as a leader for the GHI. As a result, placing the initiative at the Department of State represented a practical alternative to continued bureaucratic positioning. However, existing authorities vested in OGAC meant that OGAC in practice had the greatest interagency authority, while the GHI had none, other than the informal authorities conferred by the designation of a GHI coordinator by the secretary of state. Second, budget earmarks and separate funding streams for specific diseases were left untouched; that includes PEPFAR, a standalone program that accounts for roughly 70 percent of total US global health funding. In July 2012, the GHI quietly admitted defeat, walking back from its ambitious and strategic goals toward a far more modest and amorphous program of “global health diplomacy.”¹²

Continued Proliferation of US Policies and Initiatives

Fast-forward to the present, and US global health policy and infrastructure remain ad hoc, uncoordinated, and without overarching leadership, strategy, or vision. The largest global health agencies (PEPFAR, USAID, and HHS) have all issued their own separate policies,¹³ which are inconsistent with one another and make no mention of the GHI’s integrated 2009 strategy. Beyond such macro strategies, US government agencies have announced almost 30 new global health initiatives since 2009—ranging from the Global Alliance for Chronic Diseases to the Global Alliance for Clean Cookstoves and an aflatoxin control program.¹⁴ The link between these efforts and the GHI goals or agency strategies remains unclear. Even further, there are new disease-specific initiatives on H1N1 influenza and Ebola, each with its own separate appropriation process and implementation arrangements. The net result is a muddled and confusing mess that is far less effective than the sum of its global health spending parts.

Latent Economic Benefits from Global Health Engagement

Despite the deployment of massive budgetary and human resources, US global health engagement has largely ignored the importance of the health sector as a source of economic activity. As a result, the United States has missed opportunities to explore mutually beneficial trade, investment, and information exchanges.

Historically, the health sector has been an important source of jobs and economic growth in the United States and other countries of the Organisation for

Economic Co-operation and Development. The same opportunities exist in growing middle-income countries, where demand for quality health care and products is skyrocketing alongside economic growth and educational gains. Despite the global financial crisis and significant economic headwinds in many regions, total global health-care expenditures continue to increase, accounting for 10 percent of global gross domestic product.¹⁵ According to the Economist Intelligence Unit, health expenditures were projected to reach nearly \$260 billion in 2014 across Eastern and Central Europe, the Middle East and Africa, and East Asia and the Pacific.

The existing US global health architecture has not formally recognized these important changes and opportunities. On the global health side, the export and application of US know-how and expertise to middle-income health systems and would represent a fruitful path for global health diplomacy. Although the US health system has its substantial limitations, other countries emulate elements of the US system, such as clinical training, accreditation of health-care facilities, innovative risk-sharing and payment modalities, experiences in integrated care through organizations such as Kaiser Permanente, and design of health-benefits plans in the state of Oregon, as well as a thriving civil-society voice and analytical research on health-care policy and economics. These core US strengths could be mobilized in support of policymakers in low- and middle-income countries as well as US aid programs.

On the commercial side, more can be done to facilitate investment—via the Overseas Private Investment Corporation and multilateral development banks, as well as the Office of the US Trade Representative—and to minimize barriers to trade at home and abroad, allowing US services, products, and device firms to contribute and compete on a level playing field in markets overseas.

Policy Recommendations and Implementation Roadmap

The next US president, working closely with Congress, should modernize how US global health programs are organized, deployed, and overseen. Overall, that effort should focus on strengthening global health security, ensuring maximum impact and sustainability of US taxpayer investments, and forging partnerships that advance health as a key driver of economic growth and opportunity in developing countries. These core objectives—saving lives and developing health systems



simultaneously—must be clearly defined and given high-level political support, with the goal of bringing programmatic goals in line and reducing fragmentation.

To achieve those objectives, the next presidential administration should pursue three mutually reinforcing steps:

1 Establish new US global health leadership.

First, the next US president, working closely with Congress, should establish clear global health leadership that has both the mandate and political support to enforce interagency collaboration in both international and domestic policies. Such an effort would learn from, and build upon, past efforts such as the Obama administration’s GHI. Specifically, the president should appoint a global health coordinator, who reports directly to the national security advisor, with a dotted reporting line to the domestic policy advisor. While congressional authorization would not be explicitly required, it would help to empower this new position. Ultimately, the new White House global health coordinator would oversee coordination of US government-wide policies and related budget processes.

2 Pursue a harmonized approach to multilateral organizations.

Second, the next presidential administration should more systematically engage with the largest multilateral

organizations. This includes using US funding and governance leverage to ensure that they complement US investments and effectively support US global health objectives. Moreover, the US government should lead reform efforts that improve efficiency, scale, results, and accountability. Ideally, the US government should rationalize which agencies sit on the boards of these multilateral organizations. At a minimum, the proposed global health coordinator should ensure consistency of US priorities and reform objectives.

3 Establish a new Office of Global Health Trade, Economics, and Knowledge Exchange.

Third, the next presidential administration should establish an Office of Global Health Trade, Economics, and Knowledge Exchange within the HHS Office of Global Health Affairs. The new office, which ultimately would fall under the White House global health coordinator, would be responsible for sharing US health-care know-how with policymakers and businesses in developing countries. In pursuing that agenda, the office also would collaborate with multilateral organizations and other bilateral donors to leverage health care as a driver of economic growth.

Together, these actions will reposition US engagement in global health, transforming it from its inertial, aid-based status quo to a forward-looking and strategic investor for global health today and tomorrow.



Notes

¹ See the White House and the World brief “Strengthening Incentives for a Sustainable Response to AIDS: A PEPFAR for the AIDS Transition by Mead Over and Amanda Glassman (Washington: Center for Global Development, 2015) in this volume.

² Institute for Health Metrics and Evaluation, *Financing Global Health 2013: Transition in an Age of Austerity* (Seattle, Washington: IHME, 2014).

³ These figures correspond to the decline in child mortality between 1990 and 2011. Source: D. T. Jamison et al., “Global Health 2035: A World Converging within a Generation,” *The Lancet* 382(9908): 1898–1955.

⁴ Data from International Monetary Fund Fiscal Monitor database, accessed March 18, 2015, <http://www.imf.org/external/datamapper/index.php?db=FM>.

⁵ Over and Glassman, “Transitioning US Leadership”; also Stephen Resch, Theresa Ryckman, and Robert Hecht, “Funding AIDS Programmes in the Era of Shared Responsibility: An Analysis of Domestic Spending in 12 Low-Income and Middle-Income Countries,” *The Lancet Global Health* 3(1): e52–e61, [www.thelancet.com/journals/langlo/article/PIIS2214-109X\(14\)70342-0/abstract](http://www.thelancet.com/journals/langlo/article/PIIS2214-109X(14)70342-0/abstract).

⁶ Mitchell E. Daniels, Thomas E. Donilon, and Thomas J. Bollyky, *The Emerging Global Health Crisis: Noncommunicable Diseases in Low- and Middle-Income Countries*, Independent Task Force Report No. 72 (Council on Foreign Relations Press, 2014).

⁷ Sarah Ferris, “GOP Floats Gates, Powell for Ebola Czar,” *The Hill*, October 6, 2014, <http://thehill.com/policy/healthcare/public-global-health/219953-gates-powell-floated-as-ebola-czar>.

⁸ Kaiser Family Foundation, *2013 Survey of Americans on the U.S. Role in Global Health*, November 2013, <http://kff.org/global-health-policy/poll-finding/2013-survey-of-americans-on-the-u-s-role-in-global-health/>.

⁹ Kaiser Family Foundation, “The US Government’s Global Health Architecture,” March 13, 2013, <http://kff.org/global-health-policy/slide/the-u-s-governments-global-health-architecture/>.

¹⁰ Amanda Glassman and Victoria Fan, *Does the Money Match the Message? Current Practice in Allocation of Aid for Tuberculosis and Implications for the U.S. Government* (Washington: Center for Strategic and International Studies, 2014), http://csis.org/files/publication/140604_Glassman_DoesMoneyMatchMessage_Web.pdf.

¹¹ Jen Kates, Julie Fischer, and Eric Lief, *The US Government’s Global Health Policy Architecture: Structure, Programs, and Funding* (Washington: Kaiser Family Foundation, 2009), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7881.pdf>.

¹² Amanda Glassman and Rachel Silverman, “Failure to Launch: A Post-Mortem of GHI 1.0,” *Global Health Policy Blog*, July 9, 2012, www.cgdev.org/blog/failure-launch-post-mortem-ghi-10.

¹³ PEPFAR issued new policies in 2009, 2012, and 2015. USAID and HHS each issued separate policies in 2011.

¹⁴ Kaiser Family Foundation, “Global Health Policy Tracker, <http://kff.org/policy-tracker/search>. Results compiled by CGD in Excel spreadsheet: www.cgdev.org/sites/default/files/PolicTracker_Obama_V02.xlsx.

¹⁵ Economist Intelligence Unit, *World Industry Outlook: Healthcare and Pharmaceuticals* (London: Economist Intelligence Unit, 2010).