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Health and U.S. Foreign Policy in the Age of Miracles

Authors: Thomas J. Bollyky, Senior Fellow for Global Health, Economics, and Development, and Eric Goosby, UN Special Envoy on Tuberculosis and Former U.S. Global AIDS Coordinator
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The great journalist and former CEO of the ONE Campaign Michael Elliott, who died earlier this year, called this era in global health "**the age of miracles**." Even amid concerns over recent infectious disease outbreaks and rising rates of antimicrobial resistance, it is hard to argue against the remarkable progress made over the last fifteen years.

Global deaths from malaria and tuberculosis (TB) declined **48 percent** and **47 percent**, respectively, over this period. Maternal mortality dropped **43 percent**. Deaths for children under five have halved, which means **nineteen thousand fewer** of these children die each day. More than **ten million people** with HIV/AIDS in sub-Saharan Africa are on lifesaving antiretroviral treatment, up from just one hundred thousand in 2003.

U.S. leadership and investment helped spur this progress. The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) program, created in 2003, remains the largest financial commitment of any country to global health or the treatment of a specific disease. The United States is the biggest funder of GAVI, the global vaccine alliance, as well as the Global Fund to Fight AIDS, Tuberculosis, and Malaria, which immunize and treat millions of people each year. The United States also **provides the most aid** to fight neglected tropical diseases and poor maternal and child health. These investments have been consistently bipartisan, and their returns are, quite literally, measured in reduced human suffering and longer lives around the globe.

Can this age of miracles endure? Yes, but only with continued U.S. leadership and investment amid some challenging headwinds. The next president should build on the recent efforts to harness the positive synergies between global health and U.S. foreign policy.


A woman suffering from tuberculosis in a South Sudan hospital. (Photo: Andreea Campeanu/Reuters)

Global Health Amid the Headwinds

Global health needs are changing. First, population growth, warming temperatures, urbanization, and easier trade and travel are remaking the world in ways conducive to the spread of infectious disease. The recent Ebola and Zika virus outbreaks have exacted a terrible toll, but a more lethal infectious disease could do far worse. The coordination and funding of international pandemic preparedness and response continues to be ad hoc, which greatly undermines their effectiveness. Time and consistent support is needed to develop competent national health systems and disease surveillance, effective diagnostics and medical countermeasures, and outbreak response and communication plans.

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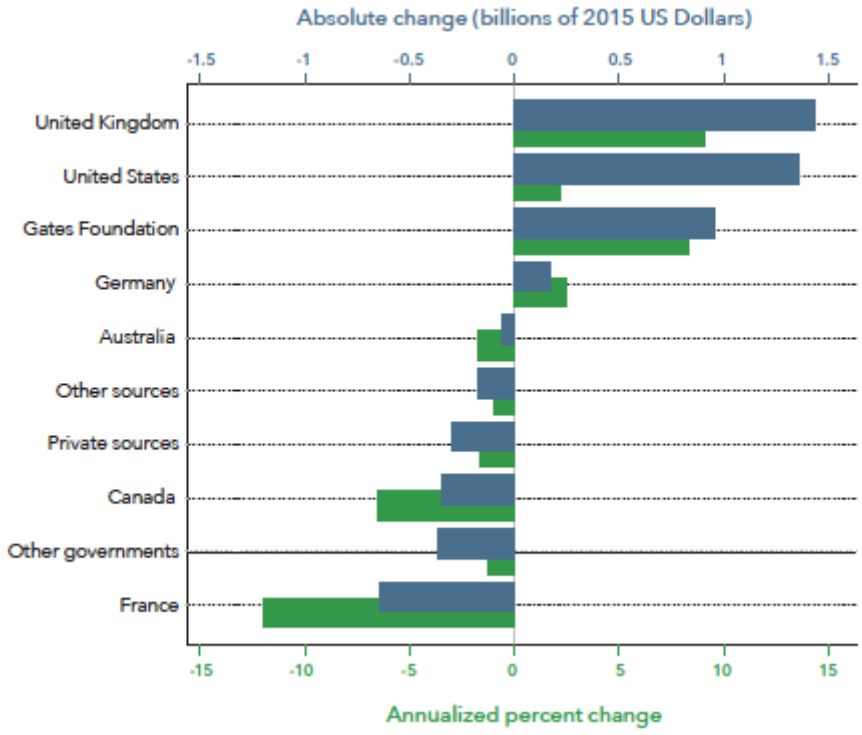
Second, rates of heart disease, cancer, diabetes, and other noncommunicable diseases (NCDs) in low- and middle-income countries are accelerating in working-age populations, rapidly outpacing declines in communicable diseases. In 2013, NCDs killed **nearly eight million people** before their sixtieth birthdays in these developing countries. Health systems in lower-income countries are ill-prepared for the scale and speed of this shift to chronic diseases. Most of these health systems are still built for acute care rather than chronic or primary care. Health spending in developing nations, though increasing, remains low. This is particularly true in low-income countries, where foreign aid accounts for 40 percent of health expenditures and where governments spend, on average, **three cents per capita on health for**

every dollar spent by high-income countries. Medicines are still purchased out of pocket in many countries and are often unaffordable for the poor.

Third, a combination of overuse of existing antibiotics and underinvestment in new ones has left the world on a precipice of **a postantibiotic era**. In 2015, **580,000 people** worldwide developed multidrug-resistant TB. Routine medical procedures, such as hip replacements and kidney dialysis, become dangerous without effective antibiotics. Even childbirth becomes more risky. The U.S. Centers for Disease Control and Prevention reports that more than two million people in the United States become infected with **antibiotic-resistant bacteria** every year, and more than twenty-three thousand die as a result. The global consequences of antimicrobial resistance are less clear, but estimates are seven hundred thousand deaths annually, including two hundred thousand from multidrug-resistant TB.

The aid environment is not favorable for addressing these new challenges. Donor support for global health has flatlined in recent years and may be poised to decline. Governments and foundations have stepped up admirably in recent fundraising for the Global Fund, but the Geneva-based organization **still needs $20 billion to fulfill its obligations over the next three years**. The United States, United Kingdom, and Bill and Melinda Gates Foundation have been primarily responsible for sustaining the current level of global health aid (Figure 1), but the UK's continued support is uncertain following the country's turn inward and vote to exit the European Union. The **apathetic global response** to the Zika virus outbreak bodes poorly for raising funds to combat future global health emergencies.



Change in Development Assistance for Health, 2010–2015 (Source: Institute for Health Metrics and Evaluation, 2015)

A Path Forward

What can the next U.S. president do to sustain and advance the last decade and a half's miraculous progress on global health amid all these emerging challenges? The full list is long, but four measures stand out.

First, further integrate global health into U.S. foreign policy and diplomacy. In 2010, President Barack Obama issued the first **U.S. Global Development Policy**, formally elevating U.S. global health and development programs to a "core pillar of American power" on par with diplomacy and defense. Secretary Hillary Clinton created the Office of Health Diplomacy in the U.S. Department of State and boosted the role of U.S. ambassadors on health.

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There would be bidirectional benefits from building on this strategy of integrating global health and U.S. foreign policy and diplomacy. Global health provides an alternative and welcome basis for U.S. engagement on non-health objectives, such as climate change, conflict prevention, reducing radicalism, and human rights. Long-term U.S. investment in the health of another country's population should not be used as leverage, but it can build trust and enable diplomatic conversations that **might otherwise be impossible**. Conversely, diplomacy helps the United States **transition** its global health programs from traditional donor-recipient relationships to partnerships in which governments are encouraged to invest more in the health of their own populations. The sustainability of U.S. investments in global health is also improved by broadening their diplomatic and foreign policy benefits, particularly at a time of fiscal austerity.

Second, shift from disease-focused objectives to outcome-oriented measures. If U.S. global health engagement is going to remain effective as a means of advancing U.S. diplomacy and foreign policy, it must advance collective security and be responsive to shifting health needs. The security of the United States or any other nation against pandemic disease and antimicrobial resistance cannot be assured at home alone. An effective response to these crossborder threats depends on other governments also building and sustaining the health and surveillance systems needed to contain and respond to threats. In poorer nations with nascent health systems, building that capacity requires international support and technical assistance, the provision of which should be tied to achievement of clear benchmarks and monitored. To be effective, that technical and funding support must be predictable rather than dependent on the media attention given to the latest disease outbreak or superbug and ad hoc emergency authorizations.

U.S. global health priorities must also include the chronic diseases and health risks that now cause the largest share of the premature health burden in lower-income nations. It is not sustainable to devote

substantial resources to fighting treatable and preventable diseases only to watch the same patients perish prematurely as a result of equally treatable and preventable conditions. U.S. programs to address HIV/AIDS and other infectious diseases provide a positive legacy on which to build. The United States should expand those programs **from disease-focused goals to more outcome-oriented measures** for improving health in targeted countries and populations. Adopting an approach based on health outcomes rather than disease-specific reduction targets, and investing in collecting the data to monitor it, would increase accountability and efficiency in U.S. global health investments and help to transition them to local government ownership.

Third, elevate global health, development, and pandemic preparedness. Responsibility for U.S. global health, development, and pandemic preparedness is spread across different directorates at the National Security Council. Ad hoc coordination among these staffs undermines planning and effective response in a crisis, such as the early days of the recent Ebola outbreak. Building on the **recommendation** of former Ebola czar Ron Klain, the next U.S. administration should appoint a deputy national security advisor for global health, development, and pandemic preparedness, which would elevate the priority of these issues and ensure U.S. investments are complementary and better coordinated. Linking the recent heightened attention to pandemic preparedness and response to more consistent advocacy and funding for global health and development might better enable both agendas to advance.

Fourth, improve U.S. interagency coordination. U.S. global health programs are **spread across** seven executive branch departments, four federal agencies, and several large, multiagency initiatives. A different agency represents the United States at each of the major multilateral global health organizations. Other U.S. agencies' priorities on trade, commerce, stabilization of fragile states, agriculture, and homeland security frequently intersect and sometimes conflict with global health concerns. The Obama administration's Global Health Initiative increased communication among the relevant U.S. departments and agencies but was not the long-term solution to interagency coordination on global health that **many have sought**.

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One way forward would be to establish a formal interagency coordinating committee for global health, development, and pandemic preparedness similar to the **Trade Policy Committee** process. The deputy national security advisor could chair this committee, and cabinet-level officials and invited agencies could comprise its membership. A staff subcommittee administered by the Office of Global Health Diplomacy could oversee interagency policy coordination. Disputes in the subcommittee could be forwarded to a review group of officials at the assistant secretary level and, if no resolution is reached, elevated to the

cabinet-level committee. To avoid duplication with other U.S. interagency processes, the jurisdiction of this committee and its subcommittees should be restricted to the sectors and issues on which health, aid, and regulatory agencies and offices have the formal lead.

Conclusion

Integrating global health into U.S. foreign policy and diplomacy has helped save lives and advance U.S. interests abroad. To sustain and expand that legacy, the next administration should continue to elevate and integrate global health, development, and pandemic preparedness in the U.S. national security architecture. Only then can the United States fulfill its foreign policy goals and prolong this "age of miracles."