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J. Stephen Morrison, Global Health Policy Center, Center for Strategic and International Studies  
Jen Kates, Kaiser Family Foundation

## **“Five emerging key challenges for US policy approaches on global health”**

The recent report from the Kaiser Family Foundation, *The U.S. Government's Global Health Policy Architecture: Structure, Programs, and Funding*, is intended to provide a comprehensive baseline presentation on those U.S. agencies, programs and authorities that today undergird the evolving U.S. approach to global health. The report grew in part out of an ongoing dialogue between CSIS and Kaiser over the scope and focus of the CSIS Commission on Smart Global Health Policy, and the kinds of analyses that would be essential for the Commission's work in 2009 and also have high value to an interested public.

Much has happened in U.S. global health approaches in the past decade. Indeed, more than the several previous post-war decades combined. The global health agenda has risen steadily in status, has become a feature of White House global leadership and U.S. foreign policy, and now commands almost \$10 billion annually, a significant component of U.S. foreign assistance. The choices that lie ahead for the next phase of U.S. engagement on global health will be very consequential, but the specific course remains a subject of ongoing debate and deliberation. Between April 2009 and early 2010, the CSIS Commission on Smart Global Health Policy will develop recommendations for a long term, strategic plan for the U.S. approach to global health. There are five broad themes that emerge from the report's analysis of the U.S. government's architecture for global health, which will be of direct relevance to the CSIS Commission's work:

First is the extent to which fragmentation of U.S. efforts hinders a coordinated and strategic response and how best to achieve maximum efficiencies and a unity of effort matched by focused, concrete impacts. This has been marked by an accretion of multiple congressional and administration initiatives, in which the global health content of programs is often an add-on to other initiatives with different, larger purposes. The risks over time include redundancies, high overheads, a spread of effort, uncertainty about concrete impacts, and significant difficulty in achieving a strategic punch.

Second is the heavy concentration of money, political capital and programs on HIV/AIDS. For most of the past decade, HIV/AIDS has been the unrivalled central focus of U.S. attention. In the period of rapid ascent, 2003-2008, the 'exceptionalism' surrounding HIV/AIDS generated tremendous momentum, had powerful radiating effects laterally across other health programs, lifting many other boats. As HIV/AIDS programs mature, as the number of persons provided through U.S. assistance with life-sustaining therapy climb rapidly, crossing the 2 million mark in 2008, and as the sense of emergency subsides, attention to addressing HIV has shifted rapidly to consideration of the long-term mortgage on provision of care and the potential crowding out effect on other forms of foreign assistance. Sustainability and continued expansion have become new big challenges. It will be a delicate task to preserve and build upon the gains in HIV/AIDS programs, while shifting from a crisis to a long-term context. It will be no less delicate to

decide upon the correct balance between HIV and other areas within the U.S. global health portfolio during the next phase of U.S. engagement. That will involve complex choices, potentially involving winners and losers or at least the perception of such.

Third, there are two historical organizing structures of the U.S. response: public health and foreign policy. Between them lies an enduring fault line: of culture, language, rationale and values. It is not enough simply to note this divide. While this duality offers some strength, drawing on two different kinds of expertise of the U.S. government, it also has been a source of tension and confusion. And to achieve a long-term strategic U.S. approach requires a conscious effort to bridge it while building on and maintaining, as much as possible, the unique strengths of each structure.

Fourth, U.S. approaches are overwhelmingly Africa-centric, overwhelmingly bilateral, and they constitute the dominant donor effort in health in Africa. Dollars, personnel, and programs are concentrated in a continent which has exceptionally high disease burdens and health systems needs but which also does not have high strategic import to U.S. national interests. With health becoming a main feature of U.S. policy approaches to Africa, it begs the question of how the U.S. engagement is best carried forward into the future. For example, there could be difficulties in making the case for continued expansion and long-term U.S. commitments, especially in a period of global economic instability and high-cost security priorities in other regions, including South Asia, the Middle East and Asia. These factors suggest the need for enhanced U.S. efforts to leverage and coordinate better with other donor agencies and partner governments, along with a long-term focused effort on building specific essential aspects of health care systems in Africa. It suggests the need for greater care and competency in demonstrating concrete impacts from U.S. investments and their links to stability and productivity. The dominant bilateral aspect to U.S. policy approaches means that in many weak state settings in Africa the United States exercises an exceptional degree of control and choice. It also means that many multilateral options, programmatically and diplomatically, remain sideshows, underexploited in the pursuit of U.S. aims.

Fifth is the pronounced vertical nature of US approaches. Institutionally and psychologically, this creates obstacles to building integration of health with related community-based developmental programs, such as maternal and child health, sanitation and clean water, agriculture and nutrition, and education. The shift to a broader development approach is probably more complex and difficult than is typically acknowledged in discussion of these issues, and information on how vertical approaches may in fact work to strengthen health systems and vice versa is few and far between (with an often simplistic assumption that they are always at odds with one another). It will be important to shift discussion on to investments in specific health subsystems (e.g. procurement, information, evaluation) and linking these investments to the delivery of concrete health services for target audiences with acute needs.