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The President's Global Health Initiative at Midterm

Progress in the Balance

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On May 5, 2009, President Obama announced the launch of the Global Health Initiative (GHI), the first ever effort to coalesce and overhaul the global health portfolio of the United States under one thematic and operational roof.[1] Asking Congress to approve $63 billion in funding over 6 years (fiscal years 2009-2014), the president called for a "new, comprehensive global health strategy" that is focused on results and on an "integrated approach."[1] In functional terms, the GHI was to bring about unity of purpose and greater coordination to a fragmented enterprise characterized by stand-alone disease-specific programs and minimal interagency synergy.[1] Viewed more broadly, the GHI, the leading worldwide global health donor, was to constitute a key ingredient of a national security framework wherein development features as prominently as diplomacy and defense.[2]

Predominantly focused on the African continent and on reducing the global burden of communicable diseases (84% of the bilateral fiscal year 2011 GHI budget), the GHI has targeted HIV/AIDS, malaria, tuberculosis, and neglected tropical diseases.[2,3] As such, the GHI is playing a key role in the quest to realize Millennium Development Goal 6 (MDG 6; Combat HIV/AIDS, malaria, and other diseases). In addition, the GHI is home to family planning and reproductive health; maternal, newborn, and child health; and nutrition programs (15% of the bilateral 2011 GHI budget).[2,3] In so doing, the GHI is also advancing MDG 4 (reduce child mortality) and MDG 5 (improve maternal health). In parallel, the GHI is committed to health system strengthening in support of its multiple programmatic initiatives.[2,3] Largely bilateral in orientation (88% of the 2011 GHI budget), the GHI nevertheless maintains a significant commitment to multilateral initiatives (eg, the Global Fund to Fight AIDS, Tuberculosis, and Malaria).[3]

Now at the midterm, at the 3-year mark, the GHI can lay claim to ongoing programs in more than 80, mostly low- and lower–middle income countries across 5 continents.[3] However, continued progress could be challenged by an austere appropriation environment,[4] unsettled leadership arrangements,[5,6] and an increasing appreciation of the significance of noncommunicable diseases.[7] Additional uncertainty is at hand by virtue of the upcoming presidential and congressional elections and their potential effect on future global health policies. Taken together, these evolving realities may well require that the GHI be significantly reconfigured if momentum and credibility are to be preserved. Such transformation is well worth the effort. Indeed, the need for and the promise of the GHI have never been greater. Moreover, the very premise of the GHI remains sound if in need of course correction. In this Viewpoint, we analyze the state of the GHI and point out potential solutions to the challenges thereof.

Faced with national deficits of historic proportions, future budgets of the GHI will likely be curtailed. The 2012 budget request of $9.785 billion has recently been enacted at a level approximating 2011 spending at $8.828 billion.[4] The 2013 budget request of $8.524 billion, the lowest since 2009, is not expected to fare better.[4] As such, these observations call into question the feasibility of realizing the hoped-for appropriation of $63 billion to the GHI over the 2009-2014 interval.[1] Even if the president's 2013 budget request is to be enacted as is, the final budget cycle of fiscal year 2014 would require that the president request and Congress appropriate a total of $20 billion if the cumulative $63 billion target is to be met. Deemed unlikely, such a scenario is further confounded by mandatory deficit reductions proscribed by the recently enacted Budget Control Act of 2011.[8] It would thus seem that the GHI will be required to adapt to a more constrained resource pool. To meet this challenge, the GHI would do well to revisit its geographic reach, programmatic scope, and operational efficiencies. Opportunities for savings abound. For example, the GHI could wind down operations in countries receiving nominal health assistance, prioritize disease targets in high-burden countries, and consolidate the purchasing power of goods and services. Much would also be gained by co-locating several GHI program areas at a single point of care. Building on existing (largely HIV/AIDS) care platforms, integrated care delivery by the GHI could take the form of a one-stop-shop community health center or of a patient-, indeed, family-centered medical home espousing coordinated primary care delivery. Successfully implemented, an integrated service provision, especially when fortified by task-shifting, stands to minimize duplication of efforts and to create all important

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cost efficiencies heretofore unattainable. Such efforts, characterized by an increasing emphasis on maternal and child health, have proven especially successful in Kenya, wherein the AIDS, Population, and Health Integrated Assistance (APHIA) program has carefully integrated a total of 6 GHI programs. Equally successful efforts at upgrading and integrating family planning and reproductive health are under way in Ethiopia under the auspices of the Health Extension Program.

An additional point of concern is the ongoing absence of a designated lead agency for the GHI, thereby limiting meaningful strategic coordination.[5,6] For most of its first 2 years, the GHI proceeded in absence of a formal governance structure. However, since January 1, 2011, the GHI has been managed by an executive director and an operations committee that comprised the leadership of the US Agency for International Development (USAID), the Office of the Global AIDS Coordinator (OGAC), and the Centers for Disease Control and Prevention (CDC).[5] As such, this so-called whole-of-government approach to governance proved controversial from its very inception. On July 3, 2012, barely 18 months after its inception, the GHI office, otherwise based in the Department of State, has been phased out in favor of a new Office of Global Health Diplomacy (GHD), the precise role and function of which remain to be fully elucidated.[6] In accordance with a "Joint Message" issued by the USAID, OGAC, CDC, and the GHI executive director, the GHD will "champion the priorities and policies of the GHI in the diplomatic arena" by shifting the focus from "leadership within the US Government to global leadership by the US Government."[6] Earlier plans to transition the GHI leadership to USAID appear to have been put on hold for the foreseeable future.[9]

Concurrent with the preceding developments, the last 2 years have witnessed a dramatic affirmation of the global importance of the noncommunicable diseases.[7] The proximate cause of more than 60% of the global death toll, noncommunicable diseases constitute the leading public health challenge of the 21st century.[7] At present, however, noncommunicable diseases are not a target of the GHI. Looking forward, it stands to reason that the GHI would do well to more tightly enmesh noncommunicable diseases within its fabric. If nothing else, noncommunicable diseases could be addressed within the existing primary care delivery platforms of the GHI. Conceivably, then, relatively modest investments might greatly increase the efficiency of the GHI as well as its effectiveness. In so doing, the GHI will have updated and upgraded its commitment to global health in its broadest sense. Moreover, the GHI will have strengthened its case for ongoing if more constrained appropriation.

Finally, the GHI, not unlike many other governmental programs, will likely be affected by the outcome of the upcoming presidential and congressional elections. Should President Obama be reelected, it is highly likely that the GHI will be the subject of a far-reaching review under the aegis of a yet-to-be appointed secretary of state. Such review will likely redefine the budgetary, governance, and programmatic elements of the GHI. The absence of detailed annual progress reports may also be addressed. Under this scenario, a reconfigured GHI will likely emerge. Far less is known about the intentions of a presumptive Romney administration. However, it is highly probable that signature programs initiated by President George W. Bush will be extended. The latter could well include the President's Emergency Plan for AIDS Relief (PEPFAR) and the President's Malaria Initiative (PMI). Whether the all-encompassing integrative vision of the GHI will be embraced is unknown. On the other hand, it is all but certain that former Governor Romney will end US funding to the United Nations Population Fund (UNFPA) and will reinstate the Mexico City Policy, which requires federally funded nongovernmental organizations to "refrain from performing or promoting abortion services . . . in other countries."[10]

The aspirational and inspirational vision of the GHI has never lost its luster. However, new realities call for a new and improved construct. First, the GHI, a veteran of 4 enacted budgets, must be reconfigured in anticipation of a smaller financial support.[4] Second, the GHI must settle on a new and unambiguous leadership structure, thereby doing away with the leaderless reality of the whole-of-government approach.[5,6] Third, the GHI can no longer afford to ignore the substantial health burden of noncommunicable diseases.[7] Only in so doing will the GHI truly thrive as it moves beyond its third anniversary to fulfill the promise of what remains a flagship initiative.

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