

MEDICINE AND SOCIETY

Why US Health Care Should Think Globally

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Abstract

Why should health care systems in the United States engage with the world's poorest populations abroad while tremendous inequalities in health status and access are pervasive domestically? Traditionally, three arguments have bolstered global engagement: (1) a moral obligation to ensure opportunities to live, (2) a duty to protect against health threats, and (3) a desire to protect against economic downturns precipitated by health crises. We expand this conversation, arguing that US-based clinicians, organizational stewards, and researchers should engage with and learn from low-resource settings' systems and products that deliver high-quality, cost-effective, inclusive care in order to better respond to domestic inequities. Ultimately, connecting "local" and "global" efforts will benefit both populations and is not a sacrifice of one for the other.

Despite its excellence in many places in clinical care, research, and innovation, the United States' health care system is marked by pervasive [disparities in health status](#) and by systemic obstacles to equitable health care service access. In recent years, for example, the infant mortality rate among non-Hispanic blacks (12.67 deaths per 1,000 live births) was estimated to be more than twice the rate for non-Hispanic whites (5.52 deaths per 1,000 live births); the infant mortality rate among non-Hispanic whites in Alabama (7.67 deaths per 1,000 live births) was estimated to be more than twice the rate for non-Hispanic whites in New Jersey (3.78 deaths per 1,000 live births) [1]. That tremendous health inequalities associated with race and geography begin even before the moment of birth attests to the lack of health justice or fair opportunity in accessing health care. Given this reality, the United States cannot afford to ignore the poorest, either at home or abroad. Instead, our health care system's players—clinicians, organizations, and governments, for example—must engage global health as a means to building stronger health care systems both at home and globally.

We seek to dispel the notion that [global health engagement](#) must come at the expense of local service by arguing for a new understanding of a supposed border between "local" and "global" work. Breaking down this false dichotomy requires de-emphasizing geographical distances or differences and focusing programmatic decisions instead on the common and communal challenges we face across contexts. First we review three

prevailing perspectives that necessitate high-income countries' global health involvement: that these countries have (1) a moral obligation to ensure basic opportunity for all people, (2) a duty to protect themselves and others against health threats, and (3) a desire to ensure global economic prosperity. Then we introduce a fourth perspective, which is potentially most relevant to daily decision making among clinicians and organizations, yet too often overlooked: engaging in thoughtful global health efforts offers us vital opportunities to learn about innovations in low-resource systems. These insights can inform and improve health care service delivery and health care reform efforts in our own communities, which, in turn, can generate new lessons for domestic and international applications. Ultimately, in our experience, global and local engagements with marginalized countries and people constitute complementary and connected, rather than exclusive or isolated, efforts. In time, what we see as "locally" productive can merge with our sense of what is "globally" productive.

High-Income Countries' Obligations to Become Involved in Global Health

Ethical, security-focused, and economic arguments have traditionally informed engagement in global health efforts. However, arguments based on mutual learning are potentially more relevant to everyday programmatic decision making.

Ethical. Philosophers such as John Rawls and Henry Shue argue that basic equality of opportunity (Rawls) and standards of [human rights](#) (Shue) must be ensured by the international community, especially where governments fail to guarantee fulfillment of those rights and opportunities for their own people [2]. Extreme deprivations of basic necessities—such that mortality for infants and children under five years of age ranges from roughly 100 to 160 deaths per 1,000 live births in the world's eight worst-off countries—are all too common and demand the attention of clinicians everywhere [3].

Security-focused. Building capacity with global partners to monitor, prevent, and respond to emergent and existing threats is a crucial line of defense against [pandemics](#), first-line pharmaceutical obsolescence (e.g., emergence of drug-resistant strains of tuberculosis or malaria), and global environmental perils. The expanded range of insect disease vectors, for example, is already proving to be one of the most visible public health consequences of climate change, blurring national and continental boundaries and extending the range of historically "tropical" diseases [4]. And systemic weaknesses, such as lack of capacity for diagnosis, information sharing, and locally appropriate response contributed to the emergence and longevity of the 2014 Ebola outbreak in West Africa [5].

Economic. Global health risks impact macroeconomic growth and recession. Guinea, Liberia, and Sierra Leone—all relatively small economies—lost \$2.2 billion in economic growth due to the Ebola crisis [6]. Conversely, a health crisis of similar scope and severity in the United States would likely have global economic ramifications.

Importantly, investments in health care can contribute to poverty alleviation, which opens new markets and generates new models of local economic development [7]. If local health crises can contribute to global economic downturns, then improving the health of the world's poorest people could also have far-reaching implications for domestic economic conditions.

Reciprocity. Most relevant to clinical practitioners, institutional stewards, and researchers is their recognition that policies and innovations from settings abroad have the potential to transform health care in the United States. This recognition has consequences for their daily decisions, such as introducing new best practices for interactions with marginalized patients, creating opportunities for [partnerships with institutions in low-income countries](#), and setting innovation agendas that focus on equity and community engagement. Successful health care systems in low-resource settings are designed to target and serve the poor in ways that are contextually appropriate—addressing social, cultural, and economic barriers to care—and make efficient use of limited resources. Among numerous public health innovations, Rwanda has tested performance-based financing to improve the use and quality of child and maternal health services [8]; piloted antiretroviral treatment led by nurses rather than physicians [9]; and deployed various local interventions to increase health insurance coverage, even in poor communities, and so reduce out-of-pocket expenditures [10]. As soaring costs increasingly threaten to make health care unaffordable, causing the greatest harm to the disenfranchised, the United States should look to systems that serve difficult-to-reach populations and deliver quality care—and do so efficiently. For example, community health workers have become integral to health care systems across sub-Saharan Africa and India, providing a model of low-cost care delivery [11]. And, in fact, US-based organizations that bridge hospital systems and their neighborhoods are beginning to implement [community health worker models](#) inspired by counterparts abroad [12]. A recent review of studies of community health workers in the United States found that such interventions improve cancer prevention and cardiovascular risk reduction and are cost effective for marginalized populations [13].

Similarly, products and methods of outreach that are developed for or in low-resource settings—where economic constraints and emerging markets can create incentives for innovation—can be useful for addressing inequities in health care knowledge, access, and quality in the United States. Examples of products developed for low-resource countries include low-cost ventilators [14] and mobile-phone-based flow cytometers used to diagnose some infections and cancers [15]. These and other innovations could be implemented within the US to lower costs of, and improve access to, health care. Methods of engagement and outreach developed for specific issues abroad can also be adapted to domestic problems. Effectively working with [local faith-based communities](#), for example, has been central to implementing behavioral or attitude-based interventions in maternal and child mortality in Sierra Leone, the Democratic Republic of

the Congo, Mozambique, and elsewhere [16]. Civic technologies, such as mTrac, which empowers health facility workers to report on medicine stock-outs [17], or U-report [18], which empowers young Ugandans to engage in public affairs and information sharing, enable improved targeting of issues and accountability, creating novel efficiencies even in low-bandwidth environments. In our experience, systems improvements and innovations like these have optimal impact when they are exchanged, adapted, and implemented across contexts. Disengaging from the global ecosystem of knowledge production is foolhardy, particularly for domestic academic medical centers that claim to deliver the next generation of health-improving care.

Simultaneously Engaging Global and Local Health Care: A Narrative

Once we recognize the importance of global interactions for improving local health care practices, managing tradeoffs can still be daunting. One organization navigating those tradeoffs is City Health Works, a New York City-based nonprofit organization working to implement community health worker (CHW) innovations based on global experience in a domestic context [19]. City Health Works serves patients with one or more chronic conditions such as asthma and diabetes; its patient population is low income and primarily Hispanic or African American. Patients benefit from one-on-one, in-person peer coaching focused on educating and motivating them to lead healthier lives. In designing the intervention, the organization's founders (including co-author PS) drew on extensive experience creating and operating CHW programs in sub-Saharan Africa [12]. By working to identify and neutralize the factors that create crises before they occur, and by using relatively low-cost CHWs rather than the expensive labor of nurses or physicians, the program promises to both improve health outcomes and reduce expenditures on preventable hospitalizations and emergency room visits.

Testing an old model in a new context can reveal challenges as well as opportunities for improvement that will benefit communities around the globe. City Health Works is addressing the core management challenges that face any CHW organization: integrating with local care systems; achieving financial sustainability; and building and maintaining information infrastructures that can provide patients, CHWs, physicians, and other care team members with the right information at the right time. These challenges limit the growth and efficacy of CHW programs everywhere. Yet, as City Health Works develops new technologies to support information collection and sharing between CHWs and primary care teams, for example, these technologies can be adapted and deployed in sub-Saharan Africa and beyond.

Opportunities for the two-way exchange of innovations between US and global CHW programs are not just aspirational but extant. City Health Works and other leaders in global and domestic CHW work are participating in a new task force, led by the Arnhold Institute for Global Health in partnership with the Office of the UN Secretary-General's Special Envoy for Health in Agenda 2030 and for Malaria, which is working to produce a

framework for sustainable, effective CHW programs in the US by drawing on global learnings. Building on a previous report focused on the investment case for CHW programs globally [20], the current task force aims to address the essential and interrelated problems of programmatic, operational, and financial sustainability. In addressing these problems for the domestic context, the task force will contribute new learnings that in turn can be applied to the benefit of CHW programs—and their patients—around the globe.

Conclusion

A desire to rectify extreme health status and health care access inequities and ensure basic opportunities to live healthy lives bolsters health care workers' aspirations to engage with international public health efforts. Even if one concedes that the United States has a special obligation to prioritize the needs of its domestic poor, recognition of significant epidemiological, economic, and informational connections across contexts should commit us to global engagement. Working towards more equitable health systems worldwide helps us all, morally and medically. Failure to capitalize on opportunities to link "global" and "local" health efforts inhibits the potential of both, to the detriment of those in the greatest need.

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Disclosure

Dr. Singh is an advisor to City Health Works and, as noted in his biosketch, director of the Arnhold Institute for Global Health. As noted in her biosketch, Ms. Stapleton is the program manager for policy at the Arnhold Institute for Global Health.

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