

Global Health Education in United State **J. Lideń***

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Abstract

With notable success, U.S. global health funding has prioritised the identification, treatment, and elimination of infectious diseases like tuberculosis, malaria, and acquired immunodeficiency syndrome caused by the human immunodeficiency virus. Even if efforts to offer on-going therapy for chronic infectious diseases should be continued and increased, Noncommunicable diseases, which account for the majority of diseases worldwide, must be addressed. 14 recommendations given by a committee of the National Academies of Sciences, Engineering, and Medicine call for continuous commitments to the eradication of infectious disease and increased focus on chronic illnesses including cardiovascular disease. These include increasing the effectiveness of early detection and treatment, reducing disease risk factors, changing the global health infrastructure to incorporate management of cardiovascular disease, forging international partners, and establishing private-public partnerships to Streamlining medical product creation and supply, boosting research and development capacity, and filling leadership shortages in global political and institutional structures are some examples of private-public initiatives to address infrastructure and financial difficulties.

Keywords: Health care Delivery; Health care Management; Health care reform

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Introduction

Elsevier's publication on the American College of Cardiology Foundation's behalf the state of the world's health is not just determined by the number of lives saved; it is also correlated with global economic growth and productivity [1]. For low- and middle-income nations, benefits from investments in global health can outweigh expenses by a factor of 9 to 20 [2]. Through initiatives like the President's Emergency Plan for AIDS Relief, the President's Malaria Initiative, the Global Fund to Fight AIDS, Tuberculosis, and Malaria, gavi, the Vaccine Alliance, and the more recent Global Health Security Agenda, it is estimated that preventing, detecting, and responding to infectious disease outbreaks can save billions of dollars annually in terms of health. The issue facing the next U.S. administration is to make sure that progress in global health is maintained and set up for future expansion [3]. Maintained and ready for expansion. Foreign aid is not "charity," but rather an investment in the wellbeing of the receiving nation, the US, and the entire world. Even while LMICs bear a disproportionate amount of the burden of diseases like ID, they are a hazard to all nations, including the United States

[4]. Numerous health dangers, including avian flu, Ebola, and Zika, are made worse by rising worldwide trade, travel, and interdependence of nations [5]. An extra 2 million people would die as a result of a mild influenza pandemic. Costs associated with the 2003 SARS pandemic ranged from \$40 to \$54 billion. The United States invested \$5.4 billion on the Ebola outbreak in 2014. Due to advancements in sanitation Twenty years ago, a report on the U.S. commitment to worldwide human health was requested from the Institute of Medicine Board on International Health [6]. In their report, they expressed appreciation for the interconnectedness of the world and the interdependence of the United States and other nations in terms of health. Twelve years later, a new report for the incoming Obama administration was created by an impartial group that was chosen by the IOM Board on Global Health. The U.S. Commitment to Global Health: Recommendations for the New Administration encouraged international cooperation, the creation of information-sharing networks, and funding for academic institutions and healthcare systems in LMICs. They suggested strengthening coordination throughout the American government. As a result, U.S. coordination initiatives like GHSA, PEPFAR, the President's

Malaria Initiative, and Feed Future have been successful. The National Academies of Sciences, Engineering, and Medicine were tasked with compiling suggestions for the U.S [7]. Government and other stakeholders to improve responsiveness, coordination, and efficiency in addressing global health as a follow-up to the previous two studies.

Discussion

The Committee came to a consensus on 14 recommendations via a thorough and evidence-based consensus process [8]. If adopted, these proposals will result in a robust global health policy and sustain America's position as a global health leader [9]. The full report of the Committee contains complete reference lists, a detailed explanation of the Committee's methodology, and meeting agendas. A growing number of children are living to adulthood thanks to advancements in sanitation and ID prevention. However, this prolonged life expectancy has encouraged an increase in adult-onset chronic diseases [10]. The most prevalent of these, including cardiovascular disease CVD, chronic obstructive pulmonary disease (COPD), cancer, and diabetes, are all linked to a rise in the prevalence of behavioural risk factors, such as cigarette use, sedentary behaviour, and calorie-, sugar-, and salt-rich diets. Nearly 75% of the 40 million people who die each year from chronic NCDs, including CVD, reside in LMICs [11]. Lower national productivity, higher health and welfare costs, unforeseen absences from work, and higher accident rates are all consequences of NCD [12]. Investors are also less willing to invest in economies with a high prevalence of diseases among the work population [13]. NCDs disproportionately impact the poor in middle-income countries, while frequently being characterised as a problem in western, high-income countries. And the growing urbanisation will further accelerate that tendency [14]. The human and economic consequences of the increase in NCDs in LMICs have an impact on U.S. interests; nations with a higher NCD burden typically have poorer national productivity and higher health and welfare expenditures. Up to four times as much is spent on treatment as a result of productivity losses brought on by disabilities, unscheduled absences from work, and an increase in accidents. Additionally, investors are reluctant to invest in markets with a high prevalence of diseases among the work force. By 2030, it is predicted that the increased financial burden of diseases like cardiovascular disease, chronic obstructive pulmonary disease, cancer, diabetes, and mental illness will result in output losses totalling \$47 trillion, or around 10% of world GDP in 2010. Providers and a lack of laws governing dangerous substances like tobacco. Health systems in LMICs are often not set up to address patients' long-term medical requirements; instead, they are meant to tackle IDs, not NCDs. Taken together, these shortcomings in system design and lack of training can contribute to poor quality of care, which can further deter individuals from seeking health care [15]. Many patients choose not to seek or continue in chronic medical treatments due to high out-of-pocket costs, or they steer toward the informal sector where there may be less regulation surrounding safest and best practises. Policymakers frequently concentrate on the healthcare issue that is currently in front of them and find it challenging to focus on health objectives that can seem far off or just abstract. The "slow

epidemic" of NCDs just does not inspire the same level of fright or quick action that IDs like Ebola, multidrug-resistant tuberculosis, or HIV-AIDS can inspire.

Conclusion

The United States cannot afford to overlook the serious strategic issue posed by the rising global burden of CVD and other NCDs. Currently, IDs like HIV/AIDS, TB, and malaria receive the majority of U.S. funding for global health. There is no specific funding for NCDs in the United States at the moment, and there are no presidential measures to lessen their burden. However, the United States profits in numerous ways from funding the worldwide effort to combat CVD and other NCDs. By adding CVD and other NCD, three important benefits stand to be gained. They will lose their health, which has benefits for healthier societies and more stable economies. According to a World Economic Forum research, a number of "best buy" treatments and risk factor reductions that can be easily implemented at the population and individual level in LMICs have been identified. Between 2011 and 2025, the total cost of implementing all of the recommendations in LMICs would be \$170 billion, or about 5% of these nations' total health expenditure. At a total cost of \$120 billion, following only "best purchase" recommendations would result in a 10% drop in CVD-related mortality and a \$377 billion anticipated economic benefit. Table 1 lists interventions that may have an impact on CVD and includes both preventive and curative actions. These interventions are also in line with the recommendations made in the committee report, which included identifying and managing risk factors for major NCDs, especially through the adoption of fiscal policies and regulations that encourage healthy diets and tobacco control, as well as identifying and managing hypertension early on and integrating it with community services. Fiscal and regulatory policies and those that target service delivery are two categories under which risk factor interventions can be categorised. Tax rises on cigarettes and mandates for smoke-free workplaces are two examples of the former. The latter includes things like implementing screening programmes in busy places and incorporating extra services into medical appointments. Food labelling, taxation of sugar-sweetened beverages, and workplace interventions are examples of fiscal and policy measures. This article examines the evolution of whose place in the global health architecture during the last two decades from a historical viewpoint. As the post-Cold War world changed quickly and imposed more complicated demands on international organisations in general, but particularly in the field of global health, flaws in the structure and governance of the World Health Organization started to show up in the early 1990s. WHO reenergized and played a significant influence in determining the priorities for global health around the end of that decade and during the first half of the following. The organisation has, however, lost part of its funding over the previous ten years and some of its power to define a global health agenda. Between the health ministries and the ministries in charge of managing development aid in numerous donor member states, there is a lack of coordination in the positions, priorities, and financing decisions, as well as weak organisational leadership. 2013 Royal Society of Public Health Elsevier Ltd. is the publisher. Touts droids

reserves. Both the structure of the global health architecture and the larger political and economic framework that affects health outcomes has undergone significant changes since 1990. This page makes an effort to create a concise chronology of the time period in order to better understand these changes. There are various approaches to show how exercise levels in global health are changing. The author has decided to use three for the sake of this article: Number of Official.

References

- 1 Iyengar K, Bahl S, Vaishya R, Vaish A (2020) Challenges and solutions in meeting up the urgent requirement of ventilators for COVID-19 patients. *Diab Metabol Syndr Clin Res Rev*.
- 2 Bach S (2004) Migration patterns of physicians and nurses: still the same story? *Bull World Health Organ* 82: 624-625.
- 3 Nuzzo JB, Shearer MP (2017) International engagement is critical to fighting epidemics. *Health Security* 15: 33-35.
- 4 Rochford C, Tenneti N, Moodie R (2019) Reframing the impact of business on health: The interface of corporate, commercial, political and social determinants of health. *BMJ Glob Health* 4: e001510.
- 5 Sims LD, Peiris M (2013) one health: the Hong Kong experience with avian influenza. *Curr Top Microbiol Immunol* 365: 281-298.
- 6 Phu TD, Long VN, Hien NT (2013) Strengthening global health security capacity Vietnam demonstration project. *Morb Mortal Wkly Rep* 63: 77-80.
- 7 Vigo D, Thornicroft G, Atun R (2016) Estimating the true global burden of mental illness. *The Lancet Psychiatry* 3: 171-178.
- 8 Pooran A, Pieterse E, Davids M, Theron G, Dheda K (2013) What is the cost of diagnosis and management of drug resistant tuberculosis in South Africa? *PLOS ONE* 8: e54587.
- 9 Nuzzo JB, Shearer MP (2017) International engagement is critical to fighting epidemics. *Health Security* 15: 33-35.
- 10 Deeny SP, Poeppel D, Zimmerman JB, Roth SM, Brandauer J, et al. (2008). Exercise, APOE, and working memory: MEG and behavioral evidence for benefit of exercise in epsilon4 carriers. *Biol Psychol* 78: 179-187.
- 11 Taylor DH, Hasselblad V, Henley SJ, Thun MJ, Sloan FA (2002) Benefits of smoking cessation for longevity. *Am J Public Health* 92: 1389.
- 12 Richards NC, Gouda HN, Durham J, Rampatige R, Rodney A, et al. (2016) Disability, noncommunicable disease and health information. *Bull World Health Organ* 94: 230-332.
- 13 Clegg JB, Weatherall DJ (1999) Thalassemia and malaria: New insights into an old problem. *Proceedings of the Association of American Physicians* 111: 278-282.
- 14 Crawford J, Larsen Cooper E, Jezman Z, Cunningham SC, Bancroft E, et al. (2014) SMS versus voice messaging to deliver MNCH communication in rural Malawi: assessment of delivery success and user experience. *Glob Health Sci Pract* 2: 35-46.
- 15 Elsey B, Eskandari M (1999) Identifying the management development needs of senior executives in Iran's teaching hospitals. *J Manag Med* 13: 421-435.

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Conflict of Interest

None