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**The Changing Landscape of Global Public Health
Columbia University's Mailman School of Public Health
Kaiser Family Foundation
October 26, 2010**

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ALISTAIR AGER: So good morning. If you could take your places, we're shortly beginning. There's a couple of housekeeping announcements to begin with. At the reception yesterday evening, someone left a rather nice cotton shawl. If anyone wants to claim that, it's just here.

In terms of tables for now, find a comfortable home; I'll explain a little bit more to make sure that you're on the right table for discussion later at 10:00, and please feel free to bring your coffee or your breakfast through so we can make a reasonably prompt start.

Yesterday we worked you very hard as I think is the reasonable expectation that you would have had of us to do that. And we began by looking at some key issues that you had helped identify as key issues on an agenda for the Changing Landscape of Public Health, and with respect to that we had presentations and discussions prompting us in those four key areas, with respect to which you have those propositional questions that Linda mentioned at the beginning yesterday and is in your file on a yellow piece of paper, and this will be a valuable support for you, particularly during the next session, so please find that and bring that into vision for yourself.

So in considering those four areas, we then reviewed this idea that what was the form of leadership that was

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required from the various constituencies. We had that discussion in the afternoon with some representatives from those different groupings, and then began in the afternoon to formulate a vision and key agenda items in fulfilling that vision in the coming years. And that's appropriately and initially a sort of a high level discussion.

You have, or you will shortly have - I think you've seen in front of you - photocopies of the output from each of those groups and that's a valuable resource for us, as we write up conclusions from this meeting, but, hopefully, it's also a valuable resource for you now in your deliberations to see the themes and the issues that came across different groups.

Many of you will be familiar with the notion of word clouds and so we ran this through word clouds software last night so the words - the size of the font reflects the frequency of the word that was used there, so you get some notion here from the vision clearly leadership, public, health, global, quite appropriately there, but some of the other language we were using across the groups.

And this is not the only way to summarize, but it's one sense to quite quickly, as you're going through those documents in more detail and seeking to synthesize recurrent themes, to consider the language that we used and the commonality of some of the principles there.

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And then, not to leave it at that high level of vision, but to think of elements of agenda, these were the sorts of language that we were using. Again, capacity health, public, global, develop, leadership, the most prominent in there, but promote, south, research, et cetera following behind building, set, north, current, people, use, communities, mechanisms.

So that's just to give us a flavor, that's not a comprehensive summary of yesterday's discussion, but the sense of the foundation that we're now building on today. And principle in taking us forward in this is some reflective commentaries, and I'm going to ask Linda to come forward to introduce those who are going to make those responses for us this morning. Thank you.

LINDA FRIED: Good morning. Welcome back to our roll-up-our-sleeves day. This is, in a lot of ways, I think - the bottom line is how we think and work together today and really challenge each other to try and answer the questions that were laid out at the beginning. Of course, the four prepositional questions that came out of the planning meeting in March and ultimately through the day the interface between those four questions where, in fact, we think the changing landscape of global public health may lie.

We have 126 leaders of global public health in the room. We want to hear from all 126, but to get us started, I

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have the pleasure of introducing the four people we asked to take on the burden, if you will, of synthesizing and being provocative to help the rest of us get going.

So it's my pleasure first to introduce somebody who probably needs no introduction and that's Dr. Al Sommer. Al is the University's Distinguished Service Professor at Johns Hopkins and was previously the Dean of the Johns Hopkins Bloomberg School of Public Health for 15 years, from 1990 to 2005, and for me, a long-time friend and colleague. Al.

DR. ALFRED SOMMER: Good morning, everybody. I could easily begin this synthesis of yesterday's discussion because we agreed on practically everything, but that wouldn't be much fun, and it would bely the difficult realities confronting global public health.

We now need to distinguish between pious platitudes and potent possibilities. For the non-statistician that's a two-by-two table with two peas in every cell, at least from my personal perspective, first definitions. Is global health some grand, new paradigm or discipline? I don't believe so, but I don't think it's worth a lot of time arguing about it. What I do see it as is a further evolution of the ever-evolving field of public health which has always provided a broad tent focused on populations with all their heterogeneity and stress the importance of prevention.

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Perhaps this latest phase of public health is advanced by better recognizing the need for equality in representation between professionals and perspectives of the global north and the global south. It is, if you will, the present stage in the continuing maturation of public health, but the basic tools and the core principles remain the same, or so it seems to someone who's been at this for over four decades.

Second, the problems are, no doubt, exacerbated by globalization, by financial flows, international and private sector competition and politics, climate change and environmental degradation. These are important new realities, but they are not ones over which we have much control. Everywhere menaces of commerce and industry have far more clout and resources than ministers of health.

Third, there was much discussion and considerable argument over the need to restructure and redirect our health services, but we never discussed how little leverage and influence public health has. Just take my country. The richest - still richest, I don't know for how much longer - country on earth, we still can't get healthcare reform right.

A frontline public health agency, and there are over 3,000 independent public health jurisdictions in the U.S., are starved for resources even as our hospitals multiple their high-cost imaging machines and particle accelerators. And I

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still have a hard time finding a primary care physician for myself.

Fourth, we heard a good deal of anguished hand wringing about the demands of the many new non-state funders of global health and their exercise of the Golden Rule: They have the gold; they make the rules. By directing their use of their funds and insisting on complex, and often, contradictory reporting requirements, they have, indeed, strained local managerial capacities.

But I don't recall any discussion yesterday about the corruption and corrupt politics of many of the aid recipient nations, whether simply writing those governments a check is more likely to improve the health of their often disenfranchised citizens.

Fifth, we heard frequent admonitions for moral outrage. I would be among the first to argue that moral outrage has been a potent force for good. To a still too limited degree, it awakened the world to the need to confront AIDS, gender and sexuality-based discrimination, and to recognize patients' rights and the importance of educating women.

But I'm sure we would all agree that global health must be evidence based. While patients with AIDS have a moral claim to appropriate testing, counseling and treatment, just where

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will the vast funds for treating all those patients over the next 50 to 100 years come from?

How many non-AIDS deaths will occur while AIDS commands such a large and growing share of health expenditures? Don't unnecessary deaths from tuberculosis, cholera and pneumonia, and lack of potable water have equivalent claim morally?

We are blessed with some wonderful new, cost-effective technologies, from hepatitis and HPV, to pneumococcal conjugate and rotavirus vaccines; these need to reach the people who need them: That we can do if we do it right. But the first of this session's white papers by Caceres and Mendoza depicts a stark new reality.

Our changing epidemiologic and demographic profiles ensure growing numbers of elderly with their chronic diseases will soon overwhelm health systems still overburdened by contagious diseases. They will soon need to make informed and defensible decisions for further rationing healthcare as most countries already do. This, alone, will call for radically re-thinking the design and goals of health systems everywhere.

Global public health, with its population-wide concerns and reach, its ethical and moral mooring, and its hard data, must come to the debate prepared with systematic analyses and well thought out alternatives and their consequences, and must be well positioned for this coming existential debate,

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preferably and aggressively seated at the head of the table.

Thank you. [Applause].

LINDA FRIED: Thank you, Al. These are challenges to all of us and we'll look forward to all of us responding shortly. But first, it's my pleasure to welcome Sonia Correa to the stage, oh, there she is. Oh, good. Sonia is an example in my perspective of the multi-disciplinarity of public health with a background in architecture, a post graduate education in anthropology, and a leader in research and advocacy activities in gender equality, health and sexuality. Sonia.

SONIA CORREA: Thank you, Linda. Thank you, Linda, for the presentation. I must say that it's really an honor to share with you today the insights that yesterday's discussions have triggered in my own thinking, but at the same time it's a big challenge to try and capsule in ten minutes the catch of the net, as somebody said yesterday, was cast so widely and deeply. So if I'm missing something here, it's not because I don't think it was important, but because it's really hard and I have to make difficult choices.

I want to start with Carlos' presentation yesterday because it made me recall the 1970 Brazilian debate on public health when the image of a mosaic pattern was created to facilitate our understanding of the rapidly changing landscape in transformation of health indicators. I was asking myself if

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it's not youthful to recapture and revive that image to describe and analyze the global scenario we are moving in and discussing today.

His presentation has also raised, for me, one question that I think is interesting to pose on the table, which is, is public health - global public health simply concerned with those phenomena that can be measured at high levels of aggregation, massive phenomena? Or if the field is really living behind the burden of disease approach, moving into rights approach, should it not also be the case that it becomes increasingly concerned with the health needs and aspirations that are not easily measured at those levels?

Moving to Professor Piot, I want to thank him for his provocations in respect to innovation. Firstly, for emphasizing strongly that technological fixes, smart solution silver bullets cannot easily respond and resolve the complex social, cultural, economic, political determinants of health and well being. For those of us that have gone through the early eras of tech fix obsession with family planning and population control, it's quite appalling to see this trend being revived in the world today.

But I also want to thank Peter Piot for interrogating technophobia and anti-science trends that are also constantly reviving, including among ourselves, but also welfare.

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Building on Gita's comment on the need to incorporate in our analysis the role and impact of religious dogmatic forces, it is crucial to recall, for instance, that these forces are behind the anti-vaccine campaigns that Peter mentioned yesterday, but also, efforts to restrict access to scientific knowledge in all other areas, such as, condoms, misoprostol, emergency contraception.

On the other hand, I am also convinced that our discussions on innovation and technology cannot evade the hard questions that have been raised yesterday, also, such as, who owns innovation, or if you want to be more explicit, intellectual property rights. How is innovation developed and tested, and here, we are going to address the critical issue of clinical trials; and the difficulty raised by Professor Piot, himself, in assessing risks of new technologies.

In relation to that, I would like to suggest that maybe our engagement with this particular domain should be guided by the notion of precautionary principle that has been developed and is used in environmental debates and studies. From Catterina and Carmen's comments, I would like to recapture the key understanding that health systems are not void and beautiful abstract models. Health systems are palpable institutions populated by human beings and embedded in culture and contradiction.

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Institutional systems are, on the one hand, hard to change; on the other, they cannot be completely disrupted without risks, not just for the systems, but for people that depend on them.

In relation to health systems more broadly, I'm very pleased to verify that consistent debate is taking place with respect to the limits of vertical programs, or interventions, or the silos, and I'm saying that because in my field, which is sexual and reproductive health, what we are witnessing is the reverse trend. From the broader gender from Cairo and Beijing, we are moving back into the old silo of maternal health, and that is very worrying.

On the other hand, I cannot avoid reminding all of us that health systems are, were and remain hierarchical and very segmented and, therefore, it's really a big challenge to talk about comprehensive care.

My next comment will focus on what I consider to be the greatest achievement of this meeting: The clear and open call for the public health field to be guided by human rights principles which was compellingly underlined by many, including Professor Sachs and Professor Julio Frenk yesterday.

It is necessary to recall that this very important shift did not happen accidentally; neither was it the result of smart solutions. It came about through a long, winding and

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very rocky road. It resulted from complex and difficult discussions at many levels: closed cabinets, research sites, but also the street where people shouted for rights as we have done in Vienna in July.

This is why this Measure Break II [misspelled?] must be announced quickly and widely. I was telling Richard yesterday that Professor Sachs' speech should be posted on YouTube immediately. But as enthusiastic as I am, I cannot avoid a few cautionary notes.

Moving to rights, or articulating public health and human rights it not a magic bullet either. It implies numerous theoretical and political challenges. Human rights are multi-faceted; they imply normative and legal dimensions, but cannot be restricted to litigation. Rights and human rights are also political to a platform that must remain open to critique and interpretation.

To a large extent human rights, and particularly the younger generation of human rights, such as, reproductive rights and sexual rights, are a work in progress. The aspirational idea tabled by Professor Frenk yesterday of global citizen is another example of a work in progress. It is very inspiring, indeed, but what exactly is a global citizen?

To what, exactly, does potential citizenship refer to? Here the sovereignty paradox is sharp and clear, as it quite

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often states that they are the main sources of entitlements also the main violators of potential global citizenship as migration debates tell us.

In addition, we should be reminded that human rights are not easily applicable, or don't have any meaning in states of exception. Here I'm talking about prisons, homeless shelters, refugee camps, poor areas controlled by non-state actors that are proliferating in the 21st century.

Last, but not least, the shift towards a human rights-inspired public health frame necessarily forces us to interrogate the very notion of the humane. Who is, or not, human? Can we move beyond the binary gender conceptions of the humane? What is our relation with other living beings that inhabit the same world as us, the humans?

To conclude, and most importantly, as I see it, the shift towards rights inevitably illuminates power dimensions because, as I see it, and to quote Gita from yesterday, "talking about rights is naming and taming power." I should say that yesterday the panel discussion started a very interesting debate about power that we should continue today.

But if I'm not wrong, the discussion was fundamentally framed in terms of power concentrated in huge boxes in binary pairs: The powerful north, the powerless south; the powerful donors, the powerful private sector, the powerless states, or

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else, the good power of civil society versus the bad power of states or corporations.

Although those frames can partially describe palpable realities we are coping with, I ask myself if these conceptions of power are still productive to inform our analysis? I suspect we need more flexible and complex conceptual tools to understand how power operates in the contemporary world. I just want to exemplify with a few illustrations.

The states that may be rather powerless in relation to donors can eventually be Draconian in repressing political dissidents and sexual dissidents, or else, the states that can seem very powerful in many other domains can be easily invaded by the influence of dogmatic religious forces, and I think the U.S. is the best example.

Last, but not least, civil society is populated by those that are struggling for rights, justice, solidarity; but it's also populated by those that simply want to capture states for their own benefits. This seems, maybe, a bit despairing, but I suspect that the re-framing of the public health field is inevitably caught by these webs of power flux and we need to discuss them in a more complex manner. Thank you very much. [Applause]. And it's mine. [Laughs].

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LINDA FRIED: Thank you so much, Sonia. I can already see how the whole will be greater than the sum of the parts as we build so many perspectives on yesterday.

So now, it's my pleasure to introduce to all of you somebody we've all been working with, Cheng Feng. He is an international public health research and development leader who is currently serving as the China County Director for Family Health International.

CHENG FENG: Thank you, Linda. You may not need me - to hear from me because after Professor Sommer and Sonia's comprehensive summary, so, it's such pleasure to share what I learned from yesterday's meeting. At first I want to thank the speakers for your [inaudible] presentations and ideas and also thank the [inaudible] and experts in this room for your useful comments and contributions. For myself, it is my first time at Columbia and I really enjoy this meeting and discussion.

So I think the conference has been remarkably formulated and also the process. The format of the conference is really innovative for me and it's my first experience to participate in the conference organized in this way. So I think we have clearly four semantic areas and to guide all these questions and the very objective.

So I did read a lot. So yesterday - right now I would like to take this opportunity to add two observations. At

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first, I think we have - I have some communications and talk here in [inaudible] with experts as probably one important area we should study is the legal aspect of global public health and the - improve the international law related to global public health governance to address the public health issues in the country and the controlled disease epidemic.

So independent countries usually created its own governance - health governance system to protect their own peoples' health, but the country government, you establish your public health system and the constructing public health facilities.

So we often fail as a national health governance or national health authorities, but in recent decades, especially under the age of globalization we are experiencing a new form of global public health governance. The global health governance is built on the bilateral or multiple, multilateral collaboration among the countries, so this kind of collaboration is based on a common belief of protect the people from the health risk.

As we know more and more countries [inaudible] this new form of global health governance to handle the emerging health crisis, so global health governance that requested national/international organizations and non-governance organizations and other the other actors to coordinate the way

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and also [inaudible 9] binding international regulations and promote and protect human health and handle the public health challenges.

So the global health governance have two basic elements. So we're talking about not of the human rights, but in the [inaudible] of the consents and the mechanism of coordination and cooperation amount to different parties, so the legislation is a play where [inaudible] for building and strengthening global public health governance system.

So in recent years there have been considerable developments in international law with respect to the [inaudible] definition of the right to health, which includes both healthcare and housing conditions. So this looms over a framework that shifts [inaudible] of the issues, such as, the disparities in the treatment from the question of the quality of care to the matter of the social justice.

So the right to health laid the foundation with a consensus of the value of the international law. And also, this is the consensus for the value for all actors involving the global health governance, so moreover, generally acceptance of the role of the international law should be established to promote the participation of the multi-sectorial corporation and the coordination mechanism, because as the public health practitioners, I always think about implementation.

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So if we're talking about public health governance, then this must be involved - the parties and the different agents and the different participants, so the coordination of the corporation is really important.

So this kind of collaboration can also strengthen by legislation so you can [inaudible] the established framework convention under [inaudible] control, so that is kind of an example. So the guidance of the Article 910 of the Global Tobacco Treaty will be discussed by the conference of parties in Uruguay next month. So the guidance suggests countries restrict, or prohibit, tobacco furtherance because of the attraction for the potential smokers. So this is my first comment.

My second observation or comment is about the public health system. Yesterday we discussed a lot of the public health system: education, training, and so on. So the public health system and the [inaudible] health coverage highlighted the global public health agenda. So clearly, in my mind, the objective of any global public health program is still actable access to affordable and quality health service for the poor.

So we need to engage government, the donors and the foundations, NGOs and the communities in the global health agenda to [inaudible] health coverage. I'm looking forward

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today discussing this and also hearing ideas how to put these new ideas into action. Thank you. [Applause].

LINDA FRIED: Last on the roster of the four people who graciously agreed to kick off the day, but certainly not least, is Antoine Flahault, my dear friend and colleague, who is both the Dean of the new and first EHESP French School of Public Health, Professor of Epidemiology, and today, I think, representing the Association of Schools of Public Health in the European region for which he is the President. Antoine.

ANTOINE FLAHAULT: Dear colleagues, thank you very much. Thank you, Linda, so much for this very kind invitation among this brilliant assembly. I would like also to thank the co-sponsors of this conference, the London School of Hygiene and Tropical Medicine and Peter Piot, and also the Association of the Schools of Public Health with Harrison Spencer.

We are joining - our school is joining Association of the Schools of Public Health also as an associate member and I thank you very much for this format of the conference which has been pointed by the previous speaker is very original and helps us to think different as you wanted us to do.

I've met here people who are very engaged and, as I said yesterday, we used to say in France that the generation of '68 was really engaged, but the new generation now is very connected and if we have to think different, probably we have

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to move towards this [inaudible] to stay engaged and to become connected.

I would like to raise five points. The first is probably about methods, which is probably a leg of our disciplines and maybe of the clinical epidemiology among our disciplines. This leg is about evidence-based medicine, which may be now evidence-based public health, or why not evidence-based global health?

When I say it is a leg, I mean that in all the other sciences, probably, we do not have so huge thinking about causality, about also asking, requiring, demanding a level of evidence as we have in clinical medicine and in clinical epidemiology, and that can be brought to the other disciplines and fields, particularly in fields of public health where an interdisciplinary approach is completely needed for solving problems and for solving complex intervention and complex situations.

I just want to take one example which is a French woman, Esther Duflo, she's an economist at M.I.T. in Boston, and she used - she's purely an economist, but she used the clinical epidemiology approach, randomized clinical trials to solve some complex problems regarding economics in Africa, often regarding health situations, so we are injecting some of

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our leg in other sciences, and I think this is one of the key features of public health and, probably, of global health.

The second point is regarding the move, the shift, as Julio Frenk said yesterday. The shift in paradigm is probably major in the fact that since we are moving from communicable disease to non-communicable disease, or maybe from acute disease to chronic disease, which is not completely the same because AIDS, as it has been mentioned, is also - it is becoming a chronic disease, we are probably moving from a top down approach which was a more military approach.

We used to say in public health - we used to use some wording which was from military wording: campaign, you know, alert. Alert means alerta from Italians. It was to seize enemies coming from the castle, so - alarm, take arms, all these languages, these wordings are deeply from a military approach. It is a top down approach which was believable, which was possible when that was the era of the communicable disease which was led by central top down approach.

We are moving now with a chronic disease to a [inaudible] back porch which is very important as a shift. And maybe the shift has one consequence, which has, maybe, not been deeply discussed here in this assembly yesterday, but the whole of experts, the whole of agencies and the challenge of the population towards these experts and these agencies.

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And probably, maybe 20 years ago or 30 years ago we would have discussed a lot regarding consent - informed consent forms from the - in clinical trials, in clinical research and nowadays we will - it's my intuition, we will have to discuss about conflicts of interest at the highest level to give some transparency to provide some trust when experts are speaking about matters in public health.

The third point, which is not far from this one, but which is different, is the need for accountability which most of you discussed yesterday. I am amazed to see that in many countries there is a strong need for competencies in management: management of public health, management of healthcare facilities, which cannot be non-professional.

We absolutely need to have managers who have the same level of skill as for huge companies since hospitals, since healthcare facilities nowadays use great extent of public expenses. So we absolutely need to address this issue.

The fourth point I wanted to focus on was about innovation. Innovation was brilliantly presented by Peter yesterday. We have to remind the fact that innovation is impossible to predict. Who has predicted the rise of the Internet? Who has predicted only the use of the laser when the laser was discovered.

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They never thought about the retina cure and treatment or any of the uses of the laser later on. So many innovations, many discoveries, even when they are discovered, even when they are here are very difficult to predict in the future. Peter Duinker [misspelled] used to say that we have to predict what has already happened. That is sure we cannot predict the future, but maybe we can see what can be innovation of views in our fields.

For our schools, for instance, maybe we do not measure the whole of the Internet in the future. For the press, the lay press, they have - they are facing very challenging issues with the Internet within their field, and maybe that will be the same within our schools. Maybe in the future, we will not deliver courses in the same way. Of course, we know that E-learning, distance learning is taking huge holes now in our schools, but maybe it will be more in the future.

I would like, also, to say that regarding innovation, we are often focused on technologies and maybe we have some innovations which are not only technological; maybe organizations - innovation in organizations, innovation in policy, in health policy. I am amazed to see that comparative effectiveness research was presented in your Congress in the states as a tool for adding values and maybe for funding the

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healthcare reform in the states, and that's innovation - innovative way of thinking, but not only technologies.

And the last point, my last point, is about globalization. Globalization and connection will make the world - and is making the world - much more vulnerable than before. And the iniquities which have been appropriately underlined yesterday and today are more visible and are more intolerable.

I think, also, that we need to think and to advocate that redundancies are very important. Redundancies are not efficient in an economic way. We have two eyes; we have two lungs, that is not economically efficient and that is very important because of to fight against [inaudible] abilities.

So we have also to think that there is not one north and one south; there is several norths and several souths. We cannot gather Brazil and China with Mali and Bolivia. We cannot, maybe, also gather Russia, France or the states with the UK, so we have to think about a plural world and about the complex world and that's my last point. Thank you for your attention. [Applause].

ALISTAIR AGER: Before I invite Linda to formally bring this session to a close, we're at our halfway point in the whole meeting, the synthesizing comments for a chance to reflect on that, and so, we do have an opportunity a little

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bit, like we did just before lunch yesterday, just for some comments to ourselves and to the body here.

I am going particularly to people who haven't spoken to date, but anyone in terms of some comments, some reflections on the synthesizing comments before we draw this session to a close and move on to what we've been called to do to put this new thinking into action to move from pious platitudes to make sure we're driving down to potent possibilities.

Please take a microphone and signify your eagerness to speak.

LINDA FRIED: Alistair, before we do that, may I just - I just wanted to introduce two people who have joined us last night and this morning, to welcome them and make them part of the group. Last night we were joined by Rob Lin from the Gates Foundation, and Rob, please take a bow. He's in the back. We're very, very pleased you're here. [Applause].

And this morning we were joined by Rick Clover, Rick, from the - Dean of the School of Public Health of the University of Louisville. Welcome to both of you. [Applause].

ALISTAIR AGER: I'm very happy for us to move on, but can I see a hand or someone grasping towards a microphone? Please. If you just - there you go.

MALE SPEAKER: I think several people have commented on the format of the meeting and the organizers of the meeting

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should be congratulated on the format. I think it's been very conducive, very comforting, very interactive and very informative.

I want to alert my colleagues that this is important enough as multiple north as Antoine just said. Multiple north, where are you? Antoine, that's a very interesting perspective. We're going to call it the multiple north/multiple south alliance. That is a very interesting perspective.

I've felt delighted that these multiple norths and souths had adequate representation, adequate voice and thanks for all the organizers including ASPH and the London School of Hygiene. It's a very excellent format. We should really be focusing very much in the afternoon as to how to move this forward to a long-term activity and a long-term alliance. There are three things that we mentioned that were very interesting.

One was what is a new approach towards evidence base and global health and that's part of, you know, Peter talked about innovation and that, in itself, is innovation. Is there an integrative way in which we can look at evidence base in public health in a different way than we have in the past, and can this group be assigned this responsibility of a new look, a new vision. That's number one.

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Number two is what is a new approach in global health education? And then, number three, how can this alliance forward the important task of implementing global health service delivery in a different and innovative partnership. And much of it is focused, also, on issues of equity, so I really would like for us - by the end of the day I would feel comforted if we are very, very clear on a concrete next structure that would allow us to forward these three very important ideas.

ALISTAIR AGER: Thanks, amen. Joseph. If you stand up, Joseph, that's probably going to be easiest.

JOSEPH: I just wanted to, again, to thank the organizers for giving us opportunity - people come from the south to contribute to the global health debate. I just want to remind - I've been very - it was an exciting moment to listen to new perspectives and innovative ideas. It's a very good time for me here.

I just wanted to say that I find global health by its nature is best on solidarity. You cannot do global health without thinking about solidarity. So by its nature, it's got a very strong ethical dimension in the sense that nations come out of themselves and they want to have solutions based on common sense, common interests and common good, so by its nature, it has got the sense of ethics.

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That's why I would like here to look at methodology and one of the methodologies is scientific methodology, but the other one is social methodology in the sense of attitude. And I think that you cannot talk about global health without talking about rights and ethical based approach. That's why I think as we are talking about global health, there must be another team who will be looking about global health ethics.

How do we do our global health? And I think that's very important because we see that there are a lot of resources, but global health - the problem is the question of how to distribute the resources, so again, all this has to do with rights and ethics. That's why I really push the idea of having one of the methodology is not only technology, but also how to do with attitude, rights and ethical best approach.

ALISTAIR AGER: Thanks Joseph. Siger?

SIGER: Good morning. This meeting has really touched upon many important issues, including human rights and inequity, but at the same time I think we also need to emphasize community involvement and I think that is also one of the key principles of the Alma Ata Declaration. So the involvement of communities in the design and the research and the implementation and the planning process is something which we all also need to acknowledge. Thanks.

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ALISTAIR AGER: Thank you, Siger. Final word from Robert. Sorry, Les.

ROBERT: Morning. I participated in one of the groups yesterday in the education group, and at the request of our leader, I was asked to repeat something that didn't make it to the summary sheet, so I'll just share this with you.

The best definition of education I ever heard is "education is what's left after you forget everything you've been taught." And so, the challenge for education today is how to ensure that what we do actually gets translated into practice.

And achievement of competencies, mastery of competencies is no more evidence that people will actually apply those capacities, any more than delivering a pill bottle to someone and expecting that they will actually follow directions, or delivering a vaccine and assume that it will be distributed effectively.

So as we think about education, I'll ask that you think more broadly and we talk about translating science into practice, but we rarely, if ever, raise the question what does it take to translate education into practice?

ALISTAIR AGER: Thank you, Robert. So I want to use that - all those general synthesizing comments as this transition into this next time that we have within the meeting.

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You worked very hard yesterday afternoon; it was very productive. It is hard work to be away from the Blackberry, to be away from other things to focus within a group, but we have a responsibility given the expertise within the room to really mine that to its best ability.

So I really urge you in the next hour to really feel within the group that we're trying to capture the expertise that's reflected there with respect to some key issues and those issues are reflected around those four areas for which we formulated out of the plenary meeting those propositional questions.

So just to clarify, you may well be sitting at the correct table, but you now should be on a table numbered one to eight reflecting a group assignation which puts you either looking at changing health and prevention needs, innovations in science and technology, globalization and its impact on global health governance or transforming health systems and achieving universal equity in healthcare.

If you're not at that table, I'll give you a chance to move in just a moment. Within that group, we're very much trying to follow the logic of what we were called to do to now come down to level of concreteness, to a level of identifying trackable actions towards narrowing an agenda for something that really means that we can have important engagement with

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some crucial issues. And those propositional questions on that yellow piece of paper should be of value to you.

So should the broader agendas of the different constituencies that we drew up yesterday. Can I just point out - I don't think it was their fault - that the educators hegemonically have captured the agendas of the second group of policymakers. If you look at the first sheet, it says on the lower side, "Group B Educators." Group B were not educators, they were policymakers, so that comes from that group there.

And essentially, what we're asking you in this group to do over the next hour is to identify in terms of the number of issues that have been surfaced and that are reflected in those propositional questions, what are the key issues that we should focus attention on, who should we involve in that and how we take that forward.

So your facilitators will guide you, but essentially, we're looking at those areas, we're trying to define key ways of answering those propositional questions in terms of concrete actions. Enjoy the next hour.

[END RECORDING]

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