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**Exploring HHS' Role in Global Health
& New Global Health Strategy
Kaiser Family Foundation
January 5, 2012**

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DIANE ROWLAND: Good morning. I'm Diane Rowland the Executive Vice President of the Kaiser Family Foundation, and I'm pleased to welcome you all here today to the first event of 2012 in the Barbara Jordan Conference Center. I'm very pleased that our first event is looking at a global health issue, looking at HHS's role in global health, and an ability today to discuss the new Global Health Strategy from HHS. This is a discussion today that is part of an ongoing series that we at Kaiser have been trying to sponsor to really look at the U.S. role in global health, and I'm very pleased that today we're going to be taking a look at the Department of Health and Human Services' contribution to our overall National Global Health Initiative.

What I am especially pleased about today is that we're going to be able to start our

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program and our discussion today with Secretary Sebelius and to let her kick off our discussion with some opening remarks that will set the stage for a panel discussion to follow this looking at the various dimensions of the Global Health Strategy from HHS and trying to lay out some of the major issues about how HHS interacts with other parts of the government and with the private sector. But first, we're going to turn to Secretary Sebelius and ask her to really outline for us the Global Health Initiative of the Department of Health and Human Services to look at how it fits into the broader U.S. response and to really set the stage for a discussion today of how the Department of Health and Human Services and its efforts contribute to the overall goals we have as a nation of helping to improve the health in a global sense.

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So without further ado, Secretary Sebelius we welcome you. Please join me in welcoming her to the podium.

SECRETARY KATHLEEN SEBELIUS: Well, good morning everybody. It's great to have a chance to spend a little time with you at the beginning of this important discussion and at the beginning of this important new year. I think every morning should begin in the Barbara Jordan Conference Center because you have to do something significant if you're in a room named after Barbara Jordan. I want to start by just thanking Diane for her leadership role, but also the role that the Kaiser Family Foundation has played in not only promoting discussions and dialogue like this, but for being such a gracious host.

We have some really important partners who are going to be part of the panel later today. I want to thank them personally for not only

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participating in the panel, but for their partnership role as we work on global health efforts and our Office of Global Health Affairs is ably led by Dr. Nils Daulaire. His team has not only put together the strategy I'm going to talk about a bit today, but does incredible work all over the world, and I want to especially recognize John Monahan, who is here. John was with HHS when I was recruited for this job and helped teach me a bit about this incredible opportunity and platform that we have at HHS to work on the Global Health Initiative, and it's nice to see you again, John.

Now our primary mission at the Department of Health and Human Services is to keep Americans healthy and safe and to provide essential services, particularly to the most vulnerable populations. So here in the United States it means doing everything from running Medicare to supporting community health centers to securing

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our nation's food supply. In the past, a lot of that work stopped at the country's borders. As recently as 2003, the division that has now become our Office of Global Affairs had just three employees whose main responsibility was to plan and promote the Secretary's foreign travel.

Now of course the United States was still deeply involved in global health during those years, and we had a leadership role on major initiatives like smallpox eradication. We were the number one funder in the United States of global health aid and assistance programs, and the HHS had partnerships around the world in areas like biomedical research and disease surveillance. But most of those efforts were seen really as fundamentally separate from the work to improve health here in America. So there were some global activities going on, but a very separate health agenda here and when we talked about global health

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in the past, what HHS really meant is health in other parts of the globe outside the United States borders and today that world has changed very dramatically.

We can no longer separate global health from America's health, and that's really what I want to talk about a little bit today. How that has changed. About why we need to look beyond our borders to improve the health inside our country and about how a new Global Health Strategy for all of HHS will help us do just that.

Now I was introduced to this new role of global health being America's health really on my first day on the job. I had sort of an abrupt arrival in the department. I was in Kansas serving as governor. The plan was that the Senate would vote on my confirmation and hopefully vote to confirm me; I would then resign as governor, leave that office, and come to Washington to

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assume my new role. The Senate began their debate at 10 o'clock in the morning, and I got a call at noon from the White House saying, "There is a plane that will land in an hour in Kansas. We need you on that plane, and you need to come to Washington right away."

I found out that actually the military guys involved with the plane don't have a great sense of humor because when I arrived only half jokingly I said, "So do I get a ride back if I'm not confirmed?". "Get on the plane ma'am." I was sort of serious because I had not been confirmed. I had to leave a piece of paper in my office in Kansas that said in the event I am confirmed I hereby resign because I really did not want to officially leave my job, unless I knew, actually, I had a new job, and indeed, I did get word about halfway across the country that the confirmation vote had succeeded.

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I came to Washington, was sworn in in the Oval Office with the president and then immediately went to the Situation Room because it was the outbreak of the H1N1 flu virus, an unknown strain of flu that was killing individuals, at that point in Mexico, but we had begun to have our first deaths in the United States. All people knew was it was a brand new strain that had never been seen before. So I immediately was taken to the Situation Room where I got on a several hour call with not only national partners, but international partners, the Health Minister from Mexico.

This was within two hours of my being sworn in and the first call when I got to the HHS office the next day was not from a Member of Congress or a governor, it was from Margaret Chan the Director-General of the World Health Organization who was again coordinating this

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international response. Now that was a global pandemic, and that has always been a threat, but today what we know is they can spread faster and more unpredictably than ever before. Just think about how the world has changed. As recently as 1963, 26,000 passengers came through Dulles on international flights.

In 2010, 6.4 million international passengers came through Dulles. In total more than a million people drive across our borders, dock in our ports, or land in our airports everyday and anyone of them could bring a new virus or bug with them, and it's not just people coming back and forth across the borders. The food supply has changed dramatically over the last number of years. Half of our fruit and over three-quarters of our seafood right now is imported from abroad often from countries with far

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fewer safety controls than we have here in the U.S.

So the first reason we need to look beyond our borders is very simple. In a world where the flow of people and goods stretches across the globe, our only chance to keep Americans safe is if the systems for preventing, detecting, and containing disease stretch across the globe also. But the case for taking a global approach to improving America's health is actually far more compelling than just protecting inside our borders. The single biggest health challenge we have here in the United States is really dealing with chronic disease and the cost and impact of chronic disease on our population.

Illnesses that make up the bundle of chronic diseases -- diabetes, heart disease, cancer -- kill seven out of 10 Americans, who die prematurely and also a count for three-quarters of

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our rapidly growing healthcare spending so that is the focal point of bringing down costs and improving health. To reduce the burden of chronic disease, we absolutely need a multipronged approach, including research innovations like cancer treatments that are personalized based on individual DNA, care innovations that are ways of managing diabetes and chronic illness, and public health innovations like new approaches to help people eat a healthier diet and stop smoking, two of the underlying causes of a lot of these diseases.

Now that's a huge challenge. But the good news is we don't need to develop all of those innovations on our own. Everywhere I have traveled as Secretary, from Paris to Moscow to Beijing to Nairobi, health leaders all over the globe are dealing with these very problems. It's not just dealing with chronic diseases, topics

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from rising healthcare costs to the shortage of primary care providers are typical agenda items in international meetings, and they are topics that every health leader and, frankly, every world leader is dealing with. Now every country is unique and what works in one area of the globe may not work in another, but we can certainly learn from one another and share with one another.

Research is already shared around the globe as is disease surveillance, and now we need to expand the scope of what we share, including approaches for improving population health, innovations in care delivery, and strategies for lowering costs through better care. One area, in particular, where we're learning from each other is the importance of investing in the health of women and girls. Now it's something that I've seen firsthand both in the U.S. and in my travels around the globe. When you give women better

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access to health information and services, there are huge benefits. Not just for the women themselves, but also for their children, for the families, and for entire communities and now through the president's Global Health Initiative, we're bringing a focus on women and girls to all of our global health efforts.

The collaborations also bolster America's stature around the world. One of the striking aspects of trips outside the country is how much eagerness there is to work together on health issues. In all due deference to some of my colleagues here today from other government agencies, too often countries may not want the State Department involved, certainly don't want anybody from Defense involved, but they are eager for health workers to be involved and engaged in their processes. When it comes to trade or foreign policy, there are often areas of strong

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disagreement. But when discussions turn to tackling our biggest health challenges, there's a broad consensus that nations have a lot of work to do together and there's also a wide recognition and appreciation of the critical role the United States plays in collaborative health efforts.

As Secretary Clinton has said, "At a time when people are raising questions about America's role in the world, our leadership and global health remind them of who we are and what we do." So today it's clear that to keep America healthy and safe, we need an approach that takes into account both the threats and opportunities that we find in the rest of the world, and that's exactly what our department has put forward in our first ever Global Health Strategy. I brought a prop along so you can see how pretty it is. The strategy doesn't represent a radical new direction, but it seeks to provide a focus going

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forward so we can use our department's unique expertise, resources, and relationships to make the biggest impact possible and guiding the strategy are really three pretty straightforward goals.

First, we want to focus on areas where our work abroad helps protect and promote the health and well-being of Americans. So whether it's building networks that can spot and contain emerging infectious diseases or creating important new research partnerships that help bring new treatments and cures to pharmacy aisles, we want to look for opportunities where our collaborations around the world actually improve and enhance the lives here in America.

Secondly, we want to provide leadership in areas where our department, where HHS has special technical expertise. We have limited resources, as you all know, in our government, and it makes

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sense that the department not duplicate work that's already underway or better handled by another government agency or by an NGO partner. So we want to focus our efforts on areas where HHS has unique resources and knowledge, and that starts with the world's leading researchers at NIH and its leading epidemiologists at CDC and the leading regulators at the FDA.

Finally, we want to work with our partners across the Administration to advance U.S. interest. America's global health efforts have always been a partnership between our department, the State Department, USAID, and many, many others. So, our Global Health Strategy is designed to complement these efforts and the president's Global Health Initiative. Every day, Americans experience the benefits of greater engagement in global health, whether they know it or not. We were able to respond quickly and

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effectively to the H1N1 flu in large part because of the strong international cooperation and because of the very close ties, particularly here in North America with our neighbors and friends and then around the world.

We're borrowing public health innovations first tested abroad like graphic warning labels on cigarette packages, and we continue to build closer ties in areas like biomedical research partnerships that benefit the U.S. and the world. We have come a long way, but in a world that contains more threats to America's health and more opportunities for productive health partnerships, we absolutely need to do more. Our global health agenda can't be an add-on to our efforts to improve health here in America. It has to be an extension of those efforts.

Health is the issue which aligns the interests of countries around the world. If we

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can limit the spread of pandemics, all people benefit. A new drug developed on one continent can just as easily cure sick people across the globe. A safe global food and drug supply chain will mean better health for everyone in every country, and a healthier world is one in which every nation will have more productive workers, longer lives, and larger markets for goods and services. So the U.S. can and should play an active role in shaping those critical efforts. And our department, working closely with our partners across the Administration and guided by our new Global Health Strategy will help lead the way.

So thank you all for being part of this important discussion today and again thank you to the panelists who will continue this dialogue.

Thank you very much.

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DIANE ROWLAND: And so with that let us call the panel up please. We're bringing to this discussion a very distinguished panel. I'd call it a super committee, but that term has fallen out of favor these days, so it's a super panel instead because we really wanted to be able to explore the many dimensions of the U.S. role in global health not just from the HHS perspective, but from both the NGO and the State Department and the AID perspective as well. So we're very pleased to have this panel.

We're going to start the panel discussion with a few questions to some of the panelists rather than having long presentations since as you can see if each of them talked for 15 minutes, we'd be here for quite a long time. But we really wanted to focus today on having a broad array of viewpoints so that we could engage in a discussion of global health issues and then follow up with

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questions from the audience. And our panel as you can see, their bios are all in your packet, but Nils Daulaire the Director of the Office of Global Affairs at HHS, who is going to obviously give us some more insights into the Secretary's remarks. Harvey Fineberg, the President of the Institute of Medicine where many of the studies of global health have taken place. Helene Gayle, the President and Chief Executive Officer of CARE USA with international responsibilities and then we're going to turn to Kerri-Ann Jones, the Assistant Secretary of State for Oceans and International Environment and Scientific Affairs at the U.S. Department of State and Ariel Pablos-Mendez, the Assistant Administrator for Global Health at USAID and of course, our own Jen Kates the Vice President and Director of Global Health and HIV Policy here at Kaiser.

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So I'd like to really start our discussion though by turning first to Nils and saying Nils we've just heard your Secretary describe a vision for global health and why it's important for HHS and the broader U.S. government efforts to be engaged in this work, but as head of the office, how do you plan to carry out this vision? What are some of the operational on-the-ground issues that you will be facing as you try and implement and develop this new strategy?

NILS DAULAIRE: Well, one of the things that I learned soon after coming into HHS just under two years ago was what a diverse and decentralized institution it is. HHS really is more of a holding company than it is a single entity and as the Secretary pointed out with world-class strength in CDC and NIH and FDA and its innumerable domestically oriented agencies dealing with healthcare issues and human services,

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the challenge was not in finding things that HHS was doing in global health, but in finding ways to bring it into a coherent whole. Very often we found that what HHS was doing across its different areas amounted to less than the sum of its parts.

The idea of a strategy is not to reinvent and start all over. The idea of the strategy was to pull together the key strengths of HHS and, as the Secretary pointed out, following the three major goals and to identify the principal set of objectives that we wanted to carry out and the HHS Global Health Strategy that you all have here and that will be posted online very shortly as well on HHS' website lays out 10 key objectives. I can spend the next three hours going through those. I will spare you that, but in fact, those were the distillation of months of dialogue with all of the agencies of HHS in terms of what it was that they were doing, that we were doing that was truly

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important and the summary of those comes to 10 activities that will be the focus moving forward, and that we will assure better coordination and coherence on.

Surveillance, prevention, and response are a cluster of three dealing with emerging issues and outbreaks and disasters. Supply chains and standards are two more. Supply chains and food and drug and feed and international standards by which things can be regulated to assure safety across the globe. Research and the sharing of best practices is a third cluster. This is where the U.S. has world class leading experience and expertise through HHS and other parts of the government, and we have a great deal both to share and to learn in terms of our international engagements and then the fourth cluster consists of three.

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One is addressing the changing global burden of disease, and in particular, the Secretary highlighted the growth of non-communicable diseases, which has been a real emphasis around the world for the past year and a half in terms of international engagements. The Global Health Initiative of the Obama Administration in which we're deeply involved that focuses on women and girls, maternal and child health, neglected tropical diseases, HIV AIDS, and other infectious diseases and works through a systemic approach. And last, but certainly not least, and I think Dr. Jones will refer to this later on, the role of HHS in Global Health Diplomacy where we can bring the substantive expertise married to the ability to engage constructively and sensitively with international partners.

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So in trying to bring these 10 objectives into highlight, this will now guide and direct the activities of all of HHS' agencies, and again, it's not a radical change. We've been doing all of these things, but we have been doing them in a diffuse way, and now we will do them in a much more concentrated way.

DIANE ROWLAND: And as we look at collaboration and coordination as big themes, Kerri-Ann maybe you can talk a little bit about how you see the HSS Global Health Strategy fitting into broader foreign policy agenda and maybe even comment for us with all the other international issues that are vying for attention like the European financial crisis, the Arab Spring, the rise of China, how important do you think these issues are going to remain on the international scene.

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KERRI-ANN JONES: Thank you Diane and I too would like to thank the Kaiser Family Foundation for hosting this very important event. I think there are two parts to your question. First of all, we really welcome this strategy coming out of HHS to coordinate and look across all of the different activities that these very important agencies are doing out there in the world. I think it is a very important tool in terms of our overall interagency discussion about advancing global health because we have many government partners involved as my colleague sitting next to me from USAID is one of the principal ones, but we also certainly have other agencies.

The Department of Defense is another one who is very involved in global health and we also of course have PEPFAR that is doing a lot and investing in this area so to really coordinate

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this effort requires an understanding of what each of us is doing in the field and how it's driven from our different missions. I think while this sounds very easy to say it's very challenging to do and so this strategy really is a major step forward in looking across HHS and its numerous agencies to say here's what they are doing internationally.

From our perspective it gives us a vision to say and then how does that integrate with all of the other moving parts that are out there. How can we do better together as a whole of government and I think the president's Global Health Initiative is a way that we're really trying to take that forward in a very well-defined substantive programmatic way.

To get to sort of the second part of your question about everything else that's going on in the world, I will not go into all of those other

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foreign policy issues. However, I think what you heard from Secretary Sebelius and you have certainly heard many times from Secretary Clinton is that global health is a foreign policy issue. It's a foreign policy issue because it contributes to the security and the stability of the world, and it contributes to our own national security. It contributes to stability and security of other countries because healthy populations are more stable. They tend to be more productive. This is very important. It contributes to our own security in that as Secretary Sebelius mentioned, we need to know what's going on around the world in order to understand what possible health threats may be facing our own country, and our own population because of the way things move nowadays.

It's also a foreign policy issue because of the public diplomacy aspect, and I think this

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panel and how full this room is really demonstrates that global health is very fundamental to our country. We've been committed to it for a very long time. In some ways, it represents the very best of what we take out to the world, we want to share what we have, we want to understand what's going on and having that on the foreign policy agenda really contributes to a very well-balanced partnership around the world with many different countries. It's become a fabric, part of the fabric of what our ambassadors think about as their jobs.

So I think from those two perspectives given with everything on the agenda, global health does remain a fundamental element of our foreign policy, and all of the objectives that we want to achieve.

DIANE ROWLAND: Thank you and certainly Ariel, USAID, as the biggest part of our global

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health portfolio, has a lot of interest in what HHS does and how this all fits together. Can you comment on how the work that HHS is proposing here fits with the policy framework for global health at USAID and how there may be places where you're at odds and places where you fit together?

ARIEL PABLOS-MENDEZ: Thank you Diane.

Thanks, Jen, for this opportunity. Thanks to Nils also for the invitation. It's a pleasure to be here and share my perspectives. You have a Venn diagram between development and health. I mean global health has been in that overlap and we just heard how, from the Secretary, the views of how the domestic and international are highly interrelated as well as the, in our case from USAID, the relationships to health of other sectors that also influence health in the world. These two areas have been imbalanced over the

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years, but there's been some trends if I can point to those and may help position ourselves.

The strategy fits what is I believe, a changing world. There's an inflection point in global health as we speak. We used to be called tropical medicine, Harvey would remember those days. With the end of European colonialism in Africa and Asia, we became international health. With the end of the Cold War, we became global health, and I believe we are at another period of change with the change in the political economy. Whether that will change the name of global health, I don't know, but it will certainly change the way we do our work and Secretary Clinton stated at Busan last year that 50 years ago, international development assistance accounted for 70-percent of the capital influx into developing countries, 70-percent.

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Today, it's only 13-percent and the development budgets have grown and yet capital influx from direct private investments, remittances, and so on. This changes this pace, changes the diplomatic lever, the development means, but it doesn't change the commitment of the values of global health itself. So development will remain important in the most impoverished countries, but it only makes sense to have greater coordination and integration for that smaller, proportionally smaller, part of the work with greater flexibility and innovation as predicated by the Global Health Initiative.

So, but even more importantly this not only changed in the global influx, but within countries. Countries' economies have grown tremendously and this unprecedented expansion of growth in the developing world even though OECDs have been relatively stagnant in the last five

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years or many countries in what used to be the developing world had been growing at 6, 8-percent as you all well know. This had been driven by better governance, by globalization of technology and trade, by the demographic dividend, the work in child survival and family planning has helped really boost economies around the world, and we have seen the scenario play out in Latin America. The Asian tigers are now recognized.

This is now beginning to unfold in Africa as well so the next decade will see growth of again 6, 8-percent in many African cheetahs as some people have called it. The world economy is 500-percent bigger now than 50 years ago and so that's more than twice or three times the growth of the population so per capita income has been growing for the first time in history. As countries grow in their economic development, a success story really for our effort in

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international development in the last 50 years, they tend to spend more of their money in health.

In many developing countries from Nigeria to India, Philippines, Uzbekistan, the growth of last three years, 10-percent of that growth covered the \$50 per capita needed for basic health care to all their people. So this is a different situation than where we were before. As economies grow, dependency of foreign aid will decline. Now we are seeing this. Mozambique used to be a case study of foreign international assistance shrinking as the governments themselves begin to put more of the money. So, this is changing. Domestic health spending in many of the countries we work with probably more than doubled in many African countries and most of that money unfortunately is out of pocket, 50, 80-percent in Africa and Asia and how we deal with that is important because out of pocket even though

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there's more money is now leading people back into poverty, and that will defeat development.

So this cannot be the future of health, especially as those economies indeed develop. How do we deal with this? I think part of this is there will be a transitional period in the next 10, 20 years of the role of development, of the role of health as framed in the strategy that HHS has put forward. Clearly, we need to engage BRIC countries and TIMBIs as they call it now, Turkey, Indonesia, Mexico, and so on, as emerging dollars in a changing landscape. We're also discussing how countries themselves can invest more in their own development given the larger number of poor people who now resides in middle income countries, and we need to also use the leverage that we still have in many of the countries we are focused in to help design systems for the future that will be efficient and equitable.

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This decision also means that USAID one day—people discussing USAID, some of my colleagues here, that our job is to get ourselves out of a job. To see success in development and we have indeed. I mean from missions in more than a hundred countries down to 75 countries, we are focused on about 30 countries. As overseas development assistance for health shrinks from 20-percent to less than 5-percent in countries in the next 20 years. How do we use this opportunity? This will change. I think that we need to make sure that we work in the interagency and the U.S. Government to make sure that these next 20 years have this incredible success story of the last 50 years in development and in global health.

With dreams, that have been put forward. Not dreams in the non-feasible way, but in an ambitious way of ending child death, of an AIDS-free generation, of the foundation of health

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systems for universal health coverage in the future. All of those things are now the work for the next 20 years. The economic transition also means there will be a transformation in the relationships between dollars and recipient countries to true partnerships and that's where HHS comes up again big time. This is where the strategy of HHS will have its major strength and becomes paramount for the USG leadership in the next 20 years in global health.

BRICs or TIMBI countries will seek to engage more and more with the NIH, with the FDA, with the CDC as described by Secretary Sibelius, and the role of WHO. We have to evolve to a new level of capability by the countries themselves and this change in Latin America has not been easy, but again the role of HHS in the WHO World Health Assembly and the governance bodies is paramount. This transition has already begun and

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will only progress in the next generation. HHS' strategy is well suited for this new frontier to continue USG leadership in global health and we very much look forward also to engaging, not only this traditional agencies, but also CMS, Medicare, Medicaid are very important to engage in global health as developing countries begin to develop health systems. Health system strengthening is an area where USAID has been working, and we continue to work with some new opportunities also will arise as a new era of global health emerges.

DIANE ROWLAND: Thank you. Well, we've taken a tour now through the U.S. Government's response to global health, but it's always nice to also reflect on studies that have been done and Harvey Fineberg is here with us today who in 1997 participated in an IOM Committee that looked at the U.S. role in global health, quite consistent with the Secretary's remarks, that report was

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called *America's Vital Interest in Global Health*.

In 2009 when Harvey came to head the IOM he presided over a follow up on the U.S. commitment to global health. I'd like him to sort of reflect for us today on why the 2009 report, what had and hadn't changed, and where do you think, we're going now?

HARVEY FINEBERG: Well thank you very much Diane, and it's a pleasure to be here with you and with all of my colleagues here on the panel. It's a great pleasure to have a chance to comment and reflect on the new strategy that HHS has put forward and particularly in response to your question to think about it in connection with some of the work at the Institute of Medicine. In the 1990s, as Ariel was describing, it was actually a time of transition of thinking about even the concept of global health moving from an international health construct to a global health

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construct, a difference between thinking about the problem as a problem of the other where the U.S. was giving help in other places to a notion of global health, which is not the opposite of domestic health, but rather integrating mutual needs and understanding of a shared destiny in health in the world much as the Secretary articulated.

The burden of that 1990s report was really around developing the concept of what we came to call enlightened self interest on the part of the United States in engagement in global health. But the big change over the decade and what was a principal emphasis of the report more recently was on the essential functions of health as an arm of U.S. diplomacy. Where health could serve not only as a mechanism for mutual benefit and particularly the protection of the health of the American people as well as advancing the health of others,

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but where health represents so much that is good and sharable in the United States relative to the rest of the world, the guidance of science, the role of education in our success in professional education, the importance of American values underlying what we do for health here and abroad and what we do in development as Ariel was talking about the combination of health and development.

All of these factors contribute to a very prominent place for health as an arm of American diplomacy and international relations and that was another feature that developed over the last decade. It's striking to me to see in this strategy that the Secretary introduced how extensive engagement in global health has become throughout the Department of Health and Human Services. Every agency within the department is engaged in some way. If you examine this report, you will see that there is a very systematic

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outline of goals and objectives and values and principles, and it takes us through a very eloquent description of the reasoning and rationale for health.

At the same time, growing out of the studies that you describe Diane and thinking about what's needed today, it's clear that a number of very fundamental choices will need to be made in mounting programs going forward. It's always a challenge to differentiate what parts need to be centralized and what parts need to be decentralized in carrying out programs in a government and today an environment, which is not just government, but made up of many, many nongovernment actors as well. If you're in the White House, centralized means the White House. If you're in a department, centralized means controlled in the department. If you're an agency, centralized means controlled at the head of the agency and so the meaning of

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decentralized in every place also just depends on where you relate to out beyond, and these issues have to be dealt with and understood about levels of control.

A second related element is going to be the importance of functional versus geographic control. Most of our agencies tend to want to organize by function. Most of the recipient countries want things organized geographically and reconciling attention between functional control of programs and geographic management of integrated programs is another tension that came out of those reports that I think we still need to deal with. We need to think about priorities in time. What is the near-term objectives and what are the longer-term objectives? What things are going to be necessary to do sooner? What can be put off til later?

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One feature of global health that's always been evident is that it is always important but only sometimes urgent, and to deal with the important while being prepared for the urgent is one of the necessary conditions for success in global health, and finally, all of the strategies are crying out for benchmarks of success. What will be the indicators that we have managed to accomplish the goals as we go forward? If we can do those elements, if we can incorporate those into our current strategy and integration across the government, then I think we will have incorporated and fulfilled the messages of both of those reports of the Institute of Medicine. Thank you very much.

DIANE ROWLAND: Terrific. Helene as the head of a leading development organization, but someone with great experience at both USAID and CDC, now you're in the field, how do you take this

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report, how do you think health will fit into the development agenda, and where do you think the technical issues that HHS will fit with some of the USAID issues? Just a few things?

HELENE GAYLE: Thanks Diane and I guess I'm kind of the organizational hobo among this crowd having worked for pretty much every agency or been involved in some way with reports and 20 years with CDC and HHS and USAID etcetera, so I'm going to—and now with CARE, so I'm going to speak a little bit from that vantage point, but also as a development NGO. First of all, just from the standpoint of CARE and our work as a development NGO, in some ways our approach to global health is similar to USAID's where it's in the context of our overall development mission and our mission to help to end extreme poverty around the world and so we see this report as very useful as we think about how we partner with different organizations.

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I think having a strategy is one way of developing a clearer sense of how one partners and what are the comparative advantages of different organizations and so from that perspective as CARE we really applaud this and look—you know we are a partner with HHS, particularly with CDC in some of the areas with global HIV and AIDS, maternal health, etcetera, and I think this strategy is one that will help us as we continue to hopefully be good partners with HHS and others.

But let me just step back and say a few things about why I think this report is particularly important or the strategy is particularly important and then maybe some pitfalls as well from the different perspectives. So first of all, as everyone has said, I think this is—just to have a first ever global health strategy for HHS, I think is a huge step forward and when I think of my days, particularly at CDC

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where we were one of the primary agencies within HHS working on global health and had a history, whether it was smallpox, HIV, vaccine-preventable disease efforts, etcetera, it had always had a huge role, but it did mean that there was sometimes an imbalance and sometimes even sibling rivalries because there wasn't a very clear sense of what's the comparative advantage of all the different operating divisions within HHS.

I think to have the strategy that really looks at the comparative advantage of the different organizations and operating divisions within HHS is extremely important and again, I think will help to coordinate those efforts and provide a comprehensive umbrella under which to work.

I think as been reflected, the fact that it lays out very clearly what HHS' strengths are relative to the other government organizations,

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which again, I think has been a real weakness and in the field where countries see us as the U.S. Government, we often have our different agency hats on and it leads to, I think, a very disjointed effort.

I think this effort to be able, across the different government agencies, to really have this whole of government approach by each organization having its own strategy and then having the umbrella of the Global Health Initiative under which all of these different strategies fit, I think is a huge step forward and really makes us a better partner in the field and really does give us the opportunity to have a much more cohesive approach at the country level and hopefully allow us to be more responsive in the way that we do our work.

That said, a strategy is just a beginning. I think how this actually rolls out is going to be

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incredibly important. That said, HHS's role, again, I think is particularly unique and many people have spoken to it. I think one of the reasons why I also herald this and think this is a huge step forward is it's the first time that it has been clearly enunciated, the truly global nature.

When I was at HHS and particularly at CDC, a lot of what we did was justified, as part of our domestic mission. We could do things and we would stretch this sense of how we were helping the American people. I think the very global nature of health has meant that yes, at first, focus as a domestic agency has to be the health of the American people, but that's understood at a much more global context and at a much more bidirectional way.

As the countries change, I think the bidirectional nature of global health is going to

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be more and more important where it's not just us going out and showing our technical strength and us being in the lead role but really more and more of a true partnership where more of the innovation is going to be done in other countries that we partner with.

It will mean that innovation will really not only help and be more relevant to the countries in which we're working but will also help to solve some of our problems. I think again, that bidirectional nature that comes from being primarily a domestic agency first and foremost will allow for learnings from our work globally to also help American citizens but in a way that's much more of a mutual partnership and a true bidirectional partnership.

People who've talked a lot about the benefit of health diplomacy and Jen, I'm sure you're going to talk about some of the polling

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data? No? I think one of the things that any of us who have worked in the global health arena had, in a variety of different ways, have seen that not only does it help provide a more favorable view of the United States globally, but it's the one area where the U.S. public, when you take all these polls about foreign assistance and whether people think that it's important or not, that if you ask questions about global health, and I'll let Jen give the more exact data, it's that one area that people will say this is money well spent.

Keeping children from dying, keeping women from dying in child birth, making sure that people who would've died from HIV are able to be alive to support their families, et cetera, are things that the American people actually support.

When we think about a time when we're really trying to defend foreign development

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dollars, global health are dollars well spent. I think that's another point. Again, I think with HHS that has the domestic profile, it is a good way also of it increasing the support for some of these activities for American people.

I think some of these points have been touched on. I think it's a great step forward. I think the report is a good comprehensive approach to the comparative advantages of HHS and its operating divisions. I think the fact that it moves to a more holistic, not just a disease-focused, approach allows for flexibility as diseases and as key conditions change.

As the Secretary said, we're looking more about chronic diseases than just infectious diseases. This is a flexible strategy. It will allow for that kind of flexibility. It will also allow for being responsive to the greatest needs within the countries that we're partnering with.

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I think the issue of more rapid innovation and the diffusion of innovation more rapidly because a lot of the things it will be looking at in terms of innovating will be done again in partnership and it won't be us doing things and waiting until we have to bring them to countries in other places.

I would just say, the one thing that I would highlight in terms of one of the potential pitfalls besides this just being a nice report and putting it on a shelf, is the reality that because of HHS' mandate and its primarily domestic focus, the potential for U.S. politics having an impact on our global health agenda is larger than perhaps in some of the other organizations that are primarily internationally focused like USAID and State Department.

I'll just give an example. When I was at HHS and CDC, issues around the right balance

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in HIV prevention between the A and the B and the C was often times, very controversial. There were all views on that spectrum. When I went to USAID, people at that time, nobody was focusing on how many condoms we were sending overseas because people saw that as an international issue and not part of the U.S. agenda.

I think that as we have this greater involvement of HHS and global health, making sure that U.S. politics do not trump what the needs are and that's not taking any particular view on that issue, but I think the potential for having some of the politics of U.S. health issues interface more with the global issues is something to watch for and something that I think is important.

As I go around the world, both for health as well as development, one of the things that has fed back often is unless you have your

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house in order, don't come over here and tell me how to do things. I think it puts a double burden on us for thinking about how we're evolving our own health efforts as we continue to partner with countries that are going to be stronger and stronger in their own health efforts as well as having other countries around the world that they can choose from to partner with.

I think it does mean that we have to look at our own house, making sure that we're consistent in what we do as we think about this domestic and global interface in the work that we do. I'll just close there and thank you.

DIANE ROWLAND: Thank you, Helene. Jen, I think you're going to have to mention a little bit about polling here. Also, I wanted you to put this a little bit also in context with the work that you've been doing for us through our support from Gates on the U.S. Global Health

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Architecture and on how the HHS strategy fits or doesn't fit or is advancing the overarching goal of having a Global Health Initiative that ties all of the departments together. With that—

JENNIFER KATES: Thanks Diane and thanks to all the panelists, especially Helene for setting up my remarks that I will now make.

Also, I want to say something about having this event, in working with HHS on the event because at the Foundation, much of what we do outside of what my work is domestic focused. We work with the Department of Health and Human Services and interact with the programs of the department all the time but not on the global side.

In fact, when you think of health and even people working in global health domestically, that's the agency that comes to mind. When we think about it globally, we think about it as the State Department and USAID. To

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actually have an event that sort of headlines the role of HHS, we were really excited to be able to have that discussion.

Why is that? I think it's easy—why is it that we don't think of HHS globally? I think we've heard many reasons and I just want to restate some of them. I think it's easy to look today and say the State Department and USAID have the lion share of the budget for global health, have the lion share of the authorities and the programs. Why did that happen in the first place? I think history is instructive here and we've heard some historical comments already. I'm not a historian, but I love history so I'm going to walk us down a little bit.

I think a theme that looking back into history, we've heard from everybody and I agree that the discussion around health as an arm of diplomacy is a current discussion. It's not

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always been the discussion, but I think what's interesting in the history is that it has always been the case, it just has not always been explicit.

A few years ago, we embarked on doing a report looking at the global health architecture. It came out before the Global Health Initiative and some of the strategies that we now have, and I'm happy to say it's actually outdated. A lot of the things we observed at the time, things have emerged, I won't say based on our report but there's been change that we should update because it is outdated.

DIANE ROWLAND: Jen, I think you have a new assignment.

JENNIFER KATES: I do. We're working on it. If you look back to when our government initially embraced an international health role, it was the late 19th Century and that impetus at

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the time was both economic and public health. It was never purely a public health interest. It was really economic and political motivation where our government and frankly, our trade partners realized that if they didn't come together to work out standards and conventions around how shipping ports are handled, it would affect trade and potentially bring disease across borders.

It was really driven by these interlocking concepts of promote trade, promote economic transport as well as protect our borders. That was always there. This also, when the U.S. and other nations came together and actually created the first, what was called the International Sanitary Convention, it showed that idea that health could be used as an arm of diplomacy or cooperation was all of a sudden a new concept and it led to standards, it led to

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many more of these things and eventually lead to the WHO being created in 1948.

That idea was there and because it was rooted in these different areas, it grew up both around the foreign policy and developed, at that time foreign policy arm of the government as well as the public health arm. It largely did grow up or grow out of the foreign policy side, not the public health side. There were reasons for that.

One was at the time, the State Department had already been created for more than a century. The public health service had not been formally formed until many years later. That role of working around the world was not one seen as a public health role.

This has just been reinforced over time. We heard some of the examples, if you fast forward to post-World War II, the emphasis of our country at the time was on reconstruction after

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the war and then development. That led to USAID. The development role in the world was the emphasis.

At that time, I think it's important, HHS was always the technical partner, always in all of this but not the front and center of how this got defined. Interestingly, there was a report that came out in the 70s under the Carter Administration that probably was the first attempt to look at what the U.S. Government does on global health. In that report, it talks about medical diplomacy and health diplomacy as an impetus for why we should care about what happens in the world in the 70s, when the Cold War was still a Cold War.

Post-Cold War, that really redefined how we all saw our role in the world and then we fast forward to where everyone knows, it went national security as a health concept, which frankly

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actually was before 9/11, was before AIDS was declared a national security threat in 2000. Earlier in the 80s, you can actually access now National Intelligence Council reports that are declassified that talked about the threat of AIDS becoming a security threat. These were from the 80s.

That idea had started to take hold. Of course, after 9/11, after that became a public way we discussed health as a security threat, and PEPFAR emerging, in part, because of a broader recognition of what we need to do in the world, the budget scenario came into play. The amount of money provided all of a sudden shifted the balance a little bit. It had been USAID, a little bit health, HHS and then it became State, USAID and even smaller proportion for HHS.

That really played a big role but throughout the history, HHS was not just a

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critical technical partner. I do think that what has changed is the discussion is now explicit about health as diplomacy versus implicit, where it had already been there.

I think it's ironic that here we are now, actually. We are finally having the first global health strategy from the department. I will say a little bit about the polling on two fronts. One is something that Helene mentioned. There are two kinds of polls that we've done. Normally and typically we survey the U.S. public but we did survey publics in other countries a few years ago in 40-something countries.

One of the interesting unexpected findings, because we just asked a couple questions about this, was views about the U.S. It wasn't connected to anything like what are your views about the U.S. One of the unexpected findings, and it's always when you see it have an

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unexpected finding it's kind of exciting as a researcher, was that the countries that had the biggest amount of development assistance from the U.S., primarily HIV but the biggest amount, were the most favorable towards the U.S.

We can't say what direction that goes in and how that all works, but it was a pretty surprising finding and maybe not so surprising. It's one that we would love to be able to test again because it really showed, and there's been other echoes of that, that there is a correlation.

On our surveys of the U.S. public, as Helene said, health is an area that resonates with the U.S. public - Global Health. The tight economic situation plays a role here. People really care about their pockets and their home. That's going to trump sometimes generosity at the high level, but in general, we find as the

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American public does care about global health and they think it's something that the government should be involved in, they care about the specific populations that we focus on and the ways in which we work.

One of the interesting findings to me is when we ask all these kinds of—you know. Why do you care about this? Do you think it protects Americans? Do you think it helps our economies? To some extent, people get that but really the reason that rises to the top for Americans, at least in our surveys, is it's the right thing to do. That sort of speaks to the American spirit, I guess. We should be involved in global health because it's the right thing to do.

Sometimes I think that's a little bit different than the way the political discussion happens about why we should be involved but that's what the U.S. public seems to think.

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Lastly, on the polling, we're about to be going into the field this month with a new poll on the U.S. public opinion about global health. We'll have some findings to report relatively soon. Thanks.

DIANE ROWLAND: Thank you. Now I'm going to turn back to Nils just for a second to ask him, having heard all these perspectives on your strategy, if you'd like to make a few wrap-up comments before we open it to questions.

NILS DAULAIRE: Yes and I will keep it brief because I know people do have questions. Having come to HHS after more than three decades in the global health arena, mostly in the NGO and USAID and academic space, this was something of a remarkable discovery for me to find just how deeply engaged and deeply entwined all of HHS was in global health.

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Just to give context, the Department of Health and Human Services is a nearly one trillion dollar a year enterprise. If HHS were a country, it would be the 15th largest economy in the world, about the same size as South Korea. As the Secretary pointed out, the vast majority of our activities and attention are domestically oriented. About 99.5-percent, but 0.5-percent of the trillion dollars is meaningful.

What I've seen in terms of the development of the strategy in working across the different agencies of HHS, is how very deeply engaged all of our agencies are in various aspects of the global endeavor. I think Ariel is absolutely right that we're in a transition phase with many of the largest and most significant economies in the world. Moving out of the arena of needing aid and assistance but very much wanting technical cooperation, to be treated as

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peers but eager to learn from the experience of institutions like CDC, NIH and FDA and very open to exchanges. The opening that we have, I think at this point, is enormous and the opportunity to have a profound impact on the world is here.

I'll just end with one thing that you'll find in the strategy as well which is the basic principles around which the strategy was developed which are the principles not just of our global health strategy but the principles under which HHS operates. They're to use evidence-based knowledge to inform decisions, in other words, science comes first; to leverage strengths through partnerships and coordination rather than to do everything ourselves; to respond to local needs and to build on local capacities just as parts of HHS do with state health departments and local health departments. That's the way we want to engage globally. To

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ensure lasting and measurable impact and to verify that impact rigorously. To emphasize prevention which is at the heart of everything that we do domestically; it needs to be at the core internationally. And last but certainly not least, to focus on improving equity in health so that we deal not only with the disadvantaged and under serviced here in the United States but we assure that other countries are looking equally at those issues in their own context.

DIANE ROWLAND: Thank you. And now I'm going to turn to our very patient audience and ask you to indicate if you have a question for one of the panelists or for the panel in general. We'd prefer them to be questions and not long statements. And we're going to try to take two or three questions at a time so that the panel can be responding and we can get more questions out onto the floor. When you ask a question, please

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identify yourself so that the panelists at least know who they're responding to.

JILL GAY: Jill Gay.

Whatworksforwomen.org. A question for Nils. What about—I didn't see any specific mention in the global strategy about family planning and contraception yet they're key to achieving the outcomes we need in MDG5 Maternal Health and also for HIV/AIDS. Could you please comment?

DIANE ROWLAND: Okay. Next question.
Yes.

CHRIS COLLINS: Chris Collins, amfAR, great discussion. Quick suggestion and then a question. I'd love to see one of these panels that includes the Office of the U.S. Trade Representative. I mean as we're thinking about health diplomacy going forward, our trade policy obviously is essential there particularly when we think about how trade interacts with the

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availability of generics and the president's goal around getting 6 million folks on treatment through PEPFAR.

The question is, Nils just mentioned this and Dr. Fineberg and Ariel mentioned it, but you know values is part of this, what we're doing through health diplomacy in our global health work. And I wonder if you can say more about how this strategy speaks to some values we want to advance as a nation and I think want to be seen advancing including the rights, the equality of women, most at risk populations including gay men and other men who have sex with men. Those kinds of issues; how does that feed into the global health vision that you have?

This is particularly important, of course, as we transition to more country ownership and countries taking on more of the burden. But we need to manage that transition I would argue so

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that we don't undercut things we care about like civil society engagement. That country ownership doesn't just mean government ownership and that we protect most at risk populations and advance rights as we do it. So what's HHS' role in that working with other agencies? Thanks.

DIANE ROWLAND: Okay. And we have a third question that we'll take back here. Next question so then we can respond to the first three.

JUDIT RIUS: Judit Rius, Doctors Without Borders. I would like to start by echoing Chris from amfAR's remark about the U.S. Trade Representative on the relationship between U.S. trade policies and U.S. Global Health Initiative. I would like to see U.S. Trade Representatives in this room. So I would also like to see the HHS and USAID and other agencies looking at global health at negotiations and forums where the U.S. Trade Representatives are pushing for TRIPS-lus

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policies that will endanger access to generics especially a special CO1 and the current TPP negotiation - transpacific partnership agreement negotiation.

And the question is about what's going to be the U.S. Government position in the negotiations that are currently taking place at the World Health Organization? And specifically there's an expert working group that is part of a- what we consider to be a historical process currently taking place at the World Health Organization on the relationship between innovation, public health and intellectual property. The report of this expert working group is going to be released, we believe, at the next World Health Assembly. And it's going to hopefully promote new incentive mechanisms that delink the cost of R&D from the price of the product-of medical products. And also proposals

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for new global frameworks on innovation that promote both innovation and low cost and affordability of these medicines. So we would like to see what the U.S. position's going to be in this—what we consider historical discussions.

DIANE ROWLAND: Okay. So we have women, family planning, trade, values, negotiations, innovations, WHO. Nils, you can start. And then we'll—[laughter]—we'll have—we'll join the rest of the panel. [Interposing]

NILS DAULAIRE: I will start. Jill, while family planning and contraception are not specifically noted in this report neither are lots of other substantive items. This is very much at the core of the Global Health Initiative which is one of the 10 objectives. It's very much at the core of a women and girls centered approach which the Secretary highlighted. It's very much at the core of many of the activities in prevention and

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in best practices. So it is decidedly there and the U.S. in our global health diplomacy as we've been exercising, it has been an active supporter of reproductive health and family planning globally. So I—while it is not specifically highlighted as many other things are not, we are not shy about this topic.

Second issue raised by Chris relating to the United States Trade Representative's Office, actually I'd like to introduce my two deputies, Holly Wong who is over here. Stand please just for a second. Holly has been leading the Department of HHS' interaction with the U.S. Trade Representative's Office on the very issues that you're highlighting. And we want to make sure that public health principles are well recognized and reflected in not only these trade negotiations but all trade negotiations whether they relate to

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pharmaceuticals or relate to tobacco or other issues.

And Jimmy Kolker, my other deputy who has come to us as a former ambassador from the State Department who understands the diplomatic arena, is making sure that we work constructively and well with other countries.

In terms of the final question from MSF on TRIPS- plus and innovation, let me stick with the discussion that WHO on innovation public health and IP. We were supporters of the resolution that set up this committee. We are engaged; although this is a committee, we don't steer it. So we're waiting to see what the outcome of their recommendations will be. And we'll be actively involved in discussions. From our standpoint, the key issue is in getting the best products at the most affordable prices in a sustainable fashion to the people who need them not only in the U.S. but

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around the world. So we will base our review of their recommendations on those principles.

DIANE ROWLAND: Okay. Comments from Kerri.

KERRI-ANN JONES: I just wanted to comment on the question about values and other issues that are out there. And I think it—the answer that comes to mind for me is it reinforces the importance of the partnership across all of the agencies of the U.S. Government because from the State Department perspective, the issue of the participation of all of civil society with our partner countries is something that we are trying to advance. The issue of human rights which certainly has a health dimension but has a much broader dimension in terms of participation in politics, free press, all of these pieces.

I think you know the term global health is more than just working with other countries. It's

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now looking at how global—how health connects to all of these other very fundamental issues and values that are important to the U.S. which we promote, encourage and really try to advance with our partners because we see this as part of our foreign policy agenda.

So the partnership with the foreign policy piece and this is more than the diplomacy piece in negotiations. This is just fundamental values that we try to advance. It sort of reinforces why this partnership across all of the agencies is so important.

DIANE ROWLAND: And Helene, did you want to comment?

HELENE GAYLE: Well yes, on a couple of those. You know and I would agree with Nils that the—around the family planning issue. Obviously everything doesn't go in the document. On the other hand, you know I think this is one of those

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areas that, as I said in my opening remarks, where I think the balance between some of the political tensions is important to make sure that you know we're—that we're working through those in a way that doesn't do disservice to work globally.

And I think the area of family planning, no question, is one that has been controversial and it really has cut across different administrations and different periods. And I think it is one where there's a special role and need to come—to figure out how to engage all sides of political perspectives so that the role that the U.S. has traditionally taken that has you know played a real leadership role in this area of family planning that allows for spacing children and making sure that mothers are healthy and all the reasons that you know I think are non-controversial around family planning has a fair airing so that this is not something that you know

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as Nils has said that the HHS nor other agencies are really pulling back on it.

But I think there has been more of a reluctance to talk about some of these issues. And I think until we talk about them and really come up with language that we can all rally around, it is going to continue to be one of those issues that keeps bring-being brought up. Well why are we not talking about it? Well of course, it's very much a part of any global health strategy and needs to be. And I just think we need to do a better job of figuring out how to make that less controversial, rally around the things that people—that you know I think people on all sides of the political spectrum do agree upon and really you know move that forward because the U.S. has always been a leader in that.

The comments on civil society engagement, you know it's a particularly important one for us

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as a civil society organization and one that is really working to build civil society capacity around this in the countries that we work in. And it's again why I think the whole strategy and its partnership approach is very important because it does recognize that you know organizations like HHS, AID, State Department that work government-to-government have a particular role. But then there are partners like the NGO community that can play different roles because of their relationship with communities. And I just think it is not one or the other. It's really how do we do that and how do we continue to build a strong civil society engagement in these issues?

And then you know finally on the issues of women and the—you know the central role, I think you know when I was listening to Secretary Sebelius, it could have been something from many of our different organizations that we've all—you

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know and I think we have all realized that by a focus on the health of women, it doesn't only help women. It is really what is going catalyze change not only in health of communities and nations but even more broadly—economics, peace and stability, all of these reasons. So you know I think the fact that the—that this strategy has recognized that as central you know is very key. So I would just, I guess—oh, one other thing. Sorry.

The role of industry and it isn't called out as explicitly as I think might also be useful. And I see some colleagues from the pharmaceutical industry here. You know it is a particular industry that I think again there have—there has been varying relationships with the pharmaceutical industry. But it's such a key partner in all of this that the more there can be you know even roundtables set up and you know one of the things I was going to suggest is I think one of the ways

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to keep this strategy alive is taking different pieces of it—some of the questions that people have brought up today and actually having a series of forums that look more deeply into some of these areas. And I think it would be a great opportunity to engage on issues that you know you raised around values and how we're doing that, the role of pharmaceutical and the relationship with industry, how to increase civil society engagement, a discussion around family planning and how to come up with language and a dialogue and discussion that is not polarizing and how to do that. So I actually think this could become a living, breathing kind of community [interposing] rallying point around global health. So.

DIANE ROWLAND: Thank you. Ariel.

ARIEL PABLOS-MENDEZ: Thank you.

DIANE ROWLAND: And then we're going to take our next round of questions.

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ARIEL PABLOS-MENDEZ: Family planning has been an essential pillar as you all know of USAID's work. It's essential to development. And not only does it help decrease maternal mortality, infant mortality but it actually empowers women. And that empowerment is paramount on its own as well as a driver of the economic development we have seen around the world together with globalization. So those are paramount priorities for the U.S. Government. And it has been a leader actually as you know and remains so.

The Congress has been quite supportive despite the debates and so on. In the end it has been a supporter, we all need to continue to make a case for why this is so important. And I think values when I tell my staff that in USAID that their talent is only matched by their commitment. Most of the people as you know in the USAID work in this space because they care.

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And when President Kennedy started USAID and many of the other efforts that we have heard of it's because we're recognizing support of human dignity is not a privilege of some but is really for everybody. And I guess now we would call them human rights or human dignity - it's the same point. And we have seen a peaceful revolution in human dignity in the last 50 years. And the AIDS movement in the last 20 years or so has been an important boost for that around the world. We need to keep it up.

And as when you're talking about now TRIPS and TRIPS-plus, that also has to change. It's going to change. That is it's no longer about some of the big pharma countries, you know OECD countries. Now India, Brazil, China; they will be now players in the space. How we position to engage them. An example of this, an administrator from Russia just came back from India where they

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launched a U.S.-India millennium alliance on innovation.

And the idea is that many of the innovations that developing countries are doing can be helpful in many countries. Not only antiretrovirals, there are many other things. And how that gets done in part will be the trade negotiations but in part it will also be in how we engage with countries, how we invite those countries to not only serve their people better but also leverage those innovations to serve other developing countries as well. And it will not only be about the traditional industry which is pharmaceutical but it will be about other industries that are important to health in different ways including now the emergence of IT and E-Health. And how E-Health plays out, how the IP of E-Health plays out will be important and

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it's good to start thinking about those issues now as opposed to once those things are crystallized.

DIANE ROWLAND: Okay. Next round of questions. One. Two. Three.

RONALD JOHNSON: Good morning. My name is Ronald Johnson from AIDS United. Healthcare costs and government spending or more to the point, cutting government spending is certainly an issue here and abroad. And I'd like Mr. Daulaire and the other panelists to talk about implementation of such a bold strategy in the context of so much austerity measures and efforts to control costs and cutting government spending. So again to talk about how to implement a bold strategy in that context. Thank you.

DIANE ROWLAND: Okay. Okay. Second question.

NOAM UNGER: Yes. Hi. Good morning. My name is Noam Unger from Brookings. And my

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question has to do with how the Global Health Initiative—the president's Global Health Initiative is understood and defined. It goes to a point that Dr. Fineberg and Dr. Gayle made. Dr. Fineberg talked about the tension of centralized leadership versus decentralized approach. And Dr. Gayle presented comment—praised this report as leading to you know department wide strategy that feeds into a whole of government strategy based on strategies that the State Department strategy here at HHS that all comes under—she used the term umbrella of the Global Health Initiative.

Yet I'm not sure the report actually views it that way. In the report, as I understand it, supporting GHI is number eight—the eighth objective out of 10 or maybe not. There's no order but one of 10 objectives. So my question I guess to Dr. Daulaire and Dr. Pablos-Méndez is how is GHI actually being understood and viewed? Is

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the overall moniker for the initiative perhaps a misnomer? Does this report with its breadth sort of perhaps blow the span of GHI out of the water? And should it—the next version of GHI be more encompassing of all of that this covers in terms of global health?

And I ask the question with—specifically in light of the State Department strategy that has a view towards actually moving the leadership of GHI eventually into USAID over time as it meets certain benchmarks to be able to lead the effort. Thank you.

DIANE ROWLAND: Okay. And third question.

MARK ENGMAN: Thank you very much. Mark Engman, U.S. Fund for UNICEF. Thank you all for coming. We have a big panel. We could probably have twice as many people all the different parts of government but it's great. My question is for Dr. Pablos-Méndez and perhaps Dr. Gayle could

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comment on this as well. The GHI is really important. It focuses on getting just the most basic interventions—life saving interventions to mothers and child—to children no matter where they are. That's great.

A lot of countries are starting to look at the next steps though. You know how do you build labs? How do you build clinics? How do you build health systems that can deal with a lot of things? And I'm wondering how USAID can use HHS, NIH, CDC expertise to start looking at the next steps for those countries? And Dr. Gayle, how implementers, like yourself, can start building those into your own programs?

DIANE ROWLAND: Okay. So we have the overarching issue of in an era of government spending going down and implementation having noble goals. How do we match resources with implementation and then a lot of issues around how

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all of this fits with the Global Health Initiative and with where the Global Health Initiative's going. So who would like to take the first stab? Ariel and then Nils?

ARIEL PABLOS-MENDEZ: Well there are two questions.

DIANE ROWLAND: And Kerri.

ARIEL PABLOS-MENDEZ: One --

DIANE ROWLAND: We got them all.

ARIEL PABLOS-MENDEZ: One in relation to this change in needs and how HHS plays out, the last question and then more complex questions on GHI government's transition and integration. On the first set, it is the case that this economic transition of health that I pointed out to-- together with the epidemiologic transitions that we have been witnessing around the world. They both are a result of successful development, are now calling for new ways of working. And so the

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importance of health systems, the importance of non-communicable disease and injuries will only grow. And in both cases, there's a great opportunity to leverage HHS' expertise and resources and also bring back learning domestically to our development platforms. Health systems is one of the priorities of the Global Health Initiative and is one of the priorities for the new strategic framework that USAID will also be releasing shortly.

And so and in that regard, we—it is our interest already we're working with Nils and others in CMS to also begin to engage not only the traditional CDC, NIH partners but also CMS given the experience that we have there in terms of financing, payment systems and so on. The world is increasingly hungry for that and there's a lot of learning also for the U.S. abroad in terms of health systems.

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So it's a great opportunity and one where USAID will play an important role. And we'll try to work, as we said, with HHS. NCDs is the other big agenda obviously and has not been a core part of the traditional development agenda but is now part of the reality of the problems as acknowledged by the UN General Assembly last year. And in that regard, there's plenty of opportunities. USAID has traditionally leveraged the expertise of HHS in many of the areas we work. And this is no exception. The NIH almost-most of the NIH's \$30 billion budget is in NCDs. So it's an opportunity to bring all of that public good of research into development.

The U.S. pharma investments of \$70 billion or so annually is almost all also in NCDs. Again great opportunities for us to leverage domestic resources for global public good, global public health and USAID is indeed going to be working

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with the interagency space and HHS in particular in this important arena. And we have plenty of platforms—of community platforms, health systems platforms for NCDs, vaccination programs but that is related to HPV, our efforts in nutrition and behavioral modifications will be very important in fighting obesity. Our demographic health service capability to make sure we begin to monitor systematically as we have done all of the other parameters, all of those are in motion and I see my colleague here has been leading that at USAID. So those are very important areas. I probably will allow first, let's hear from our colleagues on GHI and then I will be happy to add some remarks.

DIANE ROWLAND: Okay. Kerri-Ann.

KERRI-ANN JONES: I'd like to comment on a couple of the questions. First on trying to implement in the face of cost cutting, I think

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everyone recognizes the budget situations are going to be tight over the next few years. And I think what we see is that many agencies are involved in global health. And this effort by HHS to sort of understand and look at the breadth of what's going on is an excellent coordination effort. And that's really one of the first steps in terms of making the best investments we possibly can.

So, I think that's going to have to be something that we work much harder at. As I said in my comments, it's not an easy thing to do because each of these agencies comes from its own culture and its own mission. But I think this is part of what we're trying to get at.

And secondly about GHI, GHI is a presidential initiative that really brings forward a way of integration to look at advancing global health in developing countries. And I think all

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of the agencies involved in it have been working in an integrated manner on some very shared concepts with some very well defined objectives. And as you've mentioned in the QDDR, there is discussion about when does it move to USAID and what does this mean?

I think to really kind of understand the concept of GHI; it's an effort to make a whole of government approach on this. And I think what HHS has done in its strategy is look at GHI but also look beyond it because there are some things beyond GHI that are certainly global. But from the perspective of this Administration, GHI is the leading global health activity at this point to achieve objectives in a very integrated fashion.

That doesn't mean that, as I said, there aren't other things. But I think we are really trying to work in this integrated way and to be, as Helene pointed out, when we're out with other

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countries we're one U.S. government. Because when you look sometimes at the number of U.S. government activities in a country, it's all over the place. And it's—it can become a drain on a partner country. And so I think the effort for GHI is going to continue.

And each agency here and many others in the audience, I know the Department of Defense. There are a lot of other global health activities going on that are important to missions. They will also need to be coordinated and we need to stay informed across all of the government. But I think to try to sort of figure out all of these boxes cleanly is something that we're evolving. And there's going to be a lot of interaction between the HHS strategy as they put it out across many agencies, some GHI activities some beyond GHI. I think we just have to recognize this is the nature of global health right now.

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And then there was one other question about the next—sort of the next step. And I think what we're seeing in the emphasis on really working with partners to take a lot more country ownership I think and it's something that Ariel mentioned, we're looking at how do we shift from development assistance to true partnerships.

And this next phase is going to depend a lot more on that kind of approach where it's research laboratory to research laboratory. And countries will make investments of their own. There'll be some development assistance but it has to shift much more to a partnership role as it advances and evolves.

DIANE ROWLAND: Yes.

NILS DAULAIRE: Ronald, you asked about what austerity means for the strategy. In fact when you don't have austerity, you don't terribly much need the strategy because you can keep

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throwing money at things. The tighter things are the more important it is to have a strategy so you can make strategic decisions about what—not only what to do but what not to do. So I do not see these as opposing one another. We would all like to be in better economic circumstances but the strategy helps us to deal with where we are.

Now on the issue of where the Global Health Initiative versus HHS' Global Health Strategy fit, I'll refer you back to some of the founding documents of the Global Health Initiative which is a very targeted approach to maternal and child health, reproductive health, infectious diseases, HIV/AIDS and neglected tropical diseases. I'm sure I've left a few out and I apologize for that but not to do everything in global health, certainly not to assure this country's safe food and drug supplies, certainly not to deal with pandemic influenza preparedness

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at the global level. There are a great many things that are important and critical to be done for global health broadly and for protecting the nation's health more specifically the U.S. nation's health that are outside of the specific targeted arena of the Global Health Initiative. That doesn't mean they're in opposition. It just means that there are overlapping circles which is why we debated whether one of the objectives should specifically be the Global Health Initiative because you can look at six or seven of the other objectives and say well they contribute directly to the Global Health Initiative. But we wanted to highlight that this is an important administration priority. The Secretary is committed to it. And we will be and continue to be actively engaged.

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I'm sorry that Lois Quam wasn't able to be with us today. She could have addressed some of the GHI issues more specifically.

And finally let me just say in putting together this strategy as with the Global Health Initiative I learned a lesson many years ago that I frequently repeat which is that every model is drawn but some models are useful. [Laughter] We developed this as a way to be useful but not as a way to reflect absolute truth in the universe.

DIANE ROWLAND: Okay. Jen-[interposing]

HELENE GAYLE: I was going to-taking off from that make similar comments about the question around the Global Health Initiative and how these fit in. You know obviously you can-there is no perfect strategy. And you know I think one of the things that was good about this particular one is that it is brief enough but it-inclusive enough so that as things change over time there is that

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flexibility. And you know a strategy and particularly government strategies, which you know many of us have been involved in writing, is always just a jumping off point. It is an opportunity to state very clearly a set of principles and to express values as you mentioned, Chris. And what are the, you know, kind of overriding values that go into it? And a chance to provide that focus but it really is a jumping off point as opposed to the end all of everything.

And again I think it's an important way of organizing how entities work together and how to coordinate it. But it's only as good as it is used. And so it—you know it should not be seen either the Global Health Initiative, GHI overall or this strategy as being all inclusive versus points of departure if you will.

You—and I just wanted to also address the next step question. And Noam, you mentioned how

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does that affect a civil society organization like ours. And I think you know we work on both the supply side and the demand side. And I think a lot of what HHS and others do is to work much more on the supply side. How do we make sure that the services are available, that they are of high quality, that there is capacity being built, that there is you know mutual exchange and innovation and some of those things?

And we're involved in some of those efforts but a lot of what we try to do is to make sure that the communities in which we work actually have access. And that access is beyond whether the services are there but what's the demand? What's the ability for equal access, for use, for knowledge on the parts of community, what is available for holding governments and other agencies accountable for the things that are the rights of citizens in a country?

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And so I think you know as we look at the next steps and how health will continue to evolve in countries that we work in, we will be involved and concerned both about are the services available but also are we making sure that the communities are accessing those services, holding the right parties accountable and that it is done in a way that focuses on equity.

And again it's why I'm happy that the whole issue of equity was also stressed in this strategy because that—you know in—around the world, that's going to continue to be key. And particularly in some of the emerging nations where that gap between haves and have-nots including in health continues to increase. And we want to make sure that we don't create an unequal access to health services as we continue to evolve the quality of services available in countries around the world.

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DIANE ROWLAND: Alright Jen.

JENNIFER KATES: Yes, two just quick comments. One on the budget question, I—clearly we're in tough economic times. I think it's interesting though that given that, the global health budget has fared relatively well. That's a relative statement. But that's a sign that's important to remember.

And then the other thing and this is—Nils, not to in any way undercut your efforts to get more resources for what you're doing but I think there's a lot—if you read the strategy, there's a lot embedded in there that's not about funding. It's really about the way that—and I think this is—speaks to the unique role that HHS plays in this, the way that HHS works in the world.

One of the things and maybe this is something you could talk about, Nils, is the—that is unique about HHS is the role that it plays at

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the World Health Assembly, the role that it plays through health attachés around the world negotiating about health but often as a tool of diplomacy with multilateral or in a multilateral context and with other governments. And that's—yes, there's resources needed for that but that's not all about resources. And that's something that a lot—I think a lot of people don't know as much about. And it came up today in— many times around negotiations.

But then speaking to the issue of you know the GHI and the HHS strategy and the QDDR, I can throw in QDDR and USAID, policy framework and the president—[interposing]—the PSD, right. You know it's funny. We—so many years ago a lot of reports are—the IOM report in '97, the Carter Administration findings in the '70s, we need a Global Health Strategy. We need coordination. With the rise of global health on everyone's

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agenda, low and behold we have strategies. And we have many of them. So will that lead to more coordination? Who knows?

But I think to pick up on something that Helene said and relates back to Chris; strategies are a way of emphasis. And they are a way of stating values and what the—a government, ours or another, feels the direction should be. And so I think it—that—it is the starting point but maybe it's not as important to figure out how they all connect in the ideal world but to recognize that maybe there's some common threads throughout them. So.

DIANE ROWLAND: Ariel.

ARIEL PABLOS-MENDEZ: Thank you. We spoke before about the balance in terms of the domestic agendas—international development agendas and the mission of HHS to keep American people safe and healthy. In the development agenda which is very

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explicit about development and clearly the GHI was framed in the spirit of development. And it is the reason why the QDDR has framed a transition of that as appropriate to USAID and why USAID's strategy framework for global health, which we hope to launch here probably in a couple of weeks, is quite embedded in the GHI. But it's true that GHI is not everything. And as has been mentioned including the NCDs agendas, that is true.

And as many of you know I spent some years in the WHO, even more with the Rockefeller Foundation. I came to serve in the U.S. Government because I believe in the spirit of the Global Health Initiative. It's not only the target that's we—that have been made explicit and some of the bumps we had because of the budgets that we had expected to not be there. But I believe in the GHI because of the principles of the GHI. And again it's not about budget; it's

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the new ways of working. Clearly far more importantly that means how we engage with countries.

And two points just on how we engage with countries. There is on the one hand, the whole of government and the coordination issues. Tensions are—I always love to call them creative tensions. We have creative tensions in the public private partnership, in the north and the south, across the Atlantic all sort oftensions. They are not to hold us back. They simply are creative spaces for doing better. And I think that you have mentioned this, Harvey, before that tensions are also fractal. Whether it's at the global, people will dream of a global health architecture. Others believe there's an open source anarchy.

And I think that that openness in global health has been actually inviting. And although some people may complain about the noise, I think

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the progress that has been made because of the open engagement of NGOs, faith-based organizations, everybody's role in global health has been a—probably a much better situation than trying to have just a single WHO-led effort—and likewise the fractals within HHS, the fractals in government, GHI is trying to help us. But we know we are in a transition period. These forces of histories that I mentioned before have not been settled. GHI is now the crux of that transition. How you end up doing it right it really is about all of us working together.

Back to the issue of money. China's health spending has grown in 25 years not twice, not 10 times, 50 times. And as I said before, many developing countries a small chunk of the growth, not of the GDP, of the growth, will allow them to cover basic health needs. So the game will change. It's not only about knowledge and a

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continued support in Congress but it's also about engaging the accountability of other country, partner countries to serve the poor as we move to this incredible period for global health.

So I would like to simply say GHI's principles positioned the U.S. government and the field of global health for a new direction. It is not totally explicit because sometimes ambiguity's actually helpful when you have complexity to deal with. I'm a believer of that. And I think GHI will emerge the principle of GHI as really the light for a new path for global health not only the U.S.G. but really around the world.

DIANE ROWLAND: Okay. Now we'll take three more questions.

ALLEN DARR: Allen Darr, International Medical Corps. I'd like to ask where mental health fits in the global health agenda? If one looks at the global burden of disease, global

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disasters, war or conflict, complex emergencies and non-communicable diseases, it seems at least implicitly we're talking about mental health or behavioral health issues. And I guess the question is how do you make the implicit explicit?

DIANE ROWLAND: Okay. Do you have another qu -?

BOB BOLLINGER: Bob Bollinger from Johns Hopkins. And my question is perhaps to Dr. Fineberg and Dr. Daulaire. So I've been involved in global health for more than 30 years at the university level. And my question's about HHS' specific and strategic role in supporting engagement of U.S. universities particularly our students in global health. And over those last 30 years, I've noticed two things that I think are concerning and perhaps I could ask some comments about. The first is that while there's been an increase in funding in global health over that

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time, it's actually harder for our junior faculty and our students to get engaged in real careers in global health. And it's not as—it was easier for me than it is for my students to get started in this business.

And the other thing I would argue is that the role—the special role that universities, that our faculty and students' play in scientific diplomacy actually kind of can be even more special than what we see with CDC and USAID when the heads of agencies change, when administrations change, the universities have their boots on the ground for many, many years. And so they have a very special role. So I'm concerned about what we can do not just as a domestic job initiative but what we can do to increase the engagement of the next generation of global health students, public health students, nursing students, medical students. Because I think we really need that in

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order to take full advantage of all of the opportunities and the learning that we can bring back to our own universities in global health.

DIANE ROWLAND: Okay. And there's a third question here.

MARION THOMAS: Marion Thomas, National Institutes of Health. I was wondering about when the strategy was being drafted and put together what your indicators for success would be. I don't really see any comments about that. I would like to hear what Nils has to say about measures of outcome for success.

DIANE ROWLAND: Okay. So we have mental health. We have engagement of universities and students. And we have indicators and benchmarks in the reports. So, Harvey, do you want to start with talking about students and training a work force?

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HARVEY FINEBERG: Well thank you. I think the—one of the heartening trends of the last 10 to 15 years has been the burgeoning number of students interested in global health at every level. Undergraduate level, every professional school everywhere you go, there is a wealth of interest and a determination on the part of students to immerse themselves in this field.

There are many reasons one can identify for this but it's a reality. At the same time, it is true that it is difficult for students as they finish to find sufficient opportunity to begin to get engaged in the field. One of the things that one different report of the Institute of Medicine talked about is you know a value of a national health service corps that would be a global health service corps. And that would give opportunity for health professionals to expend their professional effort in the service of health needs

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everywhere in the world. And I think this would be one very important element.

There is a university consortium of global health that the Fogarty Center has helped to facilitate that does represent I think an important coming together of leadership at the university sector. And I certainly agree that there are many, many more possibilities for scientific and health diplomacy through universities and particularly engaging students than we have yet availed ourselves. And it's an untapped and deeply rich opportunity for our country.

HELENE GAYLE: Can I just make—?

DIANE ROWLAND: Helene.

HELENE GAYLE: —just a brief comment on that? You know I think part of the reason it's tougher too though is that I don't know that we've made the shift that we need to. Because as

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country—as people within the countries themselves develop capacity, it is a very different role that we're playing. And I—you know we see that a lot in our agency you know focused on development more broadly where you know there was a day when more—most of our staff were Americans or Europeans. Today 99-percent of the people who work in our programs come from those countries.

And I think you know we've got to make sure that what we're doing is not perpetuating a model where it was us going over to help them but really to—to really appreciate the importance of developing country—developing capacity in the countries in which we work and having that be a priority. And then looking at what are the creative ways that we can still make sure that we give global opportunities you know so that we continue that spirit of you know true mutual global learning.

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And you know as Harvey said, you can't help but go on any university and there is a student organization for global health. And they're—you know there's—there are so many students who say this is what they want their career. But I'm not sure that that shift has really taken place in terms of what does that look like. And opportunities like a global health service and others might help that.

But we really do have to think about the fact that we're no longer in the same role that we used to be in as being those who carry the knowledge. And it is a very, very different ball game. I know you know that all too well but it—that's why it was much easier for all of us who are that generation to have had careers in global health than it is today.

DIANE ROWLAND: Kerri-Ann.

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ARIEL PABLOS-MENDEZ: I think students in the '60s -

DIANE ROWLAND: Oh.

ARIEL PABLOS-MENDEZ: -helped drive this civil rights movement in which all Americans are equal. And the rights of everybody are the same. And I think this generation is sensing the same opportunity for the whole of the world's people. And that enthusiasm of the students will not respect to any labor, economics equations but is a real concern that if the overall budgets are not going to be growing at the same pace as here us, as the researchers in the NIH funding streams have experiences in the last decades is going to be an issue if it's funding to do what we were doing before. So I agree that we need to start thinking and doing things differently.

On the other hand, part of the drive for health spending growing around the world, the U.S.

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is not unique in this regard. It comes from all sort of complex drivers but one of them is labor economics differentials in productivity across sectors which will lead to not only growth in health spending but also growth in the health market. That labor that is in New York for example in 1990, 10-percent of all the jobs in the city were in health. Today over 20-percent. So that there will be an opportunity even domestically for those to engage in the space of health in ways that are complex because not-even our health systems and the provision models will also evolve. So I believe that the domestic global connection will be an important thing but that the traditional models that we had 20 years ago, they are likely to remain as they were.

HELENE GAYLE: And that-[interposing]- includes the fact that our population is becoming more global in this country. So I mean-

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[interposing]—I think it also adds another dimension to what do we mean by global health as we see a much more heterogeneous mix here in this country and a way of practicing global health, if you will, in our own backyards.

ARIEL PABLOS-MENDEZ: And not to neglect the questions as the problem itself has been neglected of mental health. Let me simply say— [interposing]—obviously we know that the burden of this is—depression and others—will only grow and dwarf most of the other problems in health around the world. We know it's happening. Part of the problem of course is that we have the problem but we don't have a clear, simple solution. And I think it's up to all of us to develop such simple solutions so that we can then develop the appropriate plans. The world will be receptive to that as will be America itself. And so I think that it is an area that is right for a lot of

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research so that we can begin to develop interventions.

In the case of the NCD agendas and the injuries agendas again it's the simplicity of having common preventive efforts that cut across cardiovascular, pulmonary, strokes and so on and so forth, cancer lends itself to interventions that are quite appealing. And I think that in addition to the growing burden of disease and the simple solutions are paramount to the agenda. So we look forward to working on developing those solutions because clearly the problem will require attention.

DIANE ROWLAND: Kerri-Ann.

KERRI-ANN JONES: Yes, I had just a very practical comment about the bureau that I lead handles not only health but also science. And there's a real interface here between the values of global health and the overall scientific values

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that we try to promote. And what I'm seeing in some programs like the AAAS Science Fellowship Program are bringing more biomedical scientists and more physicians into the State Department and USAID. I'm also seeing—we have a program on science envoys where we send eminent scientists around the world as ambassadors. Physicians are involved in that.

We—Elias Zerhouni was one of our science envoys. So I think that the interface between global health and science in terms of both development and diplomacy, there are more opportunities. And I think that sometimes we shouldn't sort of think of these as two separate areas but we really have to bring them together and look at those opportunities for students.

DIANE ROWLAND: And Nils, if you want to take on the benchmarks on mental health.

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NILS DAULAIRE: Sure. Actually let me just start with Bob's question about— [interposing]—students. As someone who is here today because as a fourth year medical student, I spent three months in Bangladesh, I'm certainly sympathetic to this growing demand among medical students. I was kind of an outlier back in my time. But I think what's very clear is first of all as Helene pointed out, global health really needs to be seen as part of what every trained nurse, doctor, paramedic, PA in the United States understands because it is going to be part of their practice. So, we've segregated it in medical education as something special that some people do because it's kind of cool to go to neat places. It needs to be mainstreamed. And I think the funding question becomes quite different when you do that.

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Secondly, you have to have a place for people to go who have this training. And as many of us at this table have found, there's no career path for global health. You sort of stumble around until you find your own way or you give up. And one of the things that we're trying to do and it's highlighted in this strategy under the tenth objective is to develop a career track within HHS so that just within the department itself there's going to be a means for people to actually have a long term engagement in global health issues so that in a sense that becomes a pull factor.

On mental health, Allen, this is an area where Secretary Sebelius has frequently expressed herself on the importance of mental health as a priority in terms of addressing non-communicable diseases. The U.S. is cosponsoring a resolution that's going to be coming before the World Health Assembly this coming May highlighting mental

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health within the broader NCD framework. And it's certainly something that's getting our attention and it fits within the eighth of the 10 objectives—the changing burden of disease.

And then Marion finally on the indicators for success, we did not go there. This is not a strategic plan. And a strategic plan needs to have indicators and benchmarks and so forth. This is a strategy. This is pre-strategic planning. We are looking to the agencies to build off this in terms of their own activities rather than to build a tightly defined strategic plan for the entire department at this point.

DIANE ROWLAND: Great. So we have a strategy to focus on. We have a panel that gave us great insights. We have a Secretary that set a tone for this discussion and for the future role of HHS in developing its strategy for global health. We've learned that global health is

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really part of American health as well as globally because we do exist within the globe. Sometimes I'm asked whether our domestic work really fits with our global health strategy and I think aren't we part of the globe? [Laughter]

And so I want to really thank the Secretary for joining us this morning and all of our panelists for being with us. And you, as an audience, for enduring this long briefing but I think very helpful. And I thank Helene for really saying to us we can go the next step and continue this discussion on many levels. And I hope you'll join us in those discussions as well. But right now, please join with me in thanking our panel for their wonderful comments. [Applause]

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