2026 GLOBAL CONFERENCE
LEADING IN A NEW ERA

GLOBAL HEALTH AS STRATEGIC SECURITY: INVESTING IN RESILIENCE AND STABILITY

Announcer 00:00

Thank you for joining us. Please welcome the panel to the stage.

Raj Kumar 00:06

All right. Nice to see everybody. Good to see some great friends in the audience. We are making up with quality for the quantity of people in this room. I'm Raj Kumar, the president editor-in-chief at Devex. Thrilled to be back here at the Milken Global Conference, and especially to bring back global health, which year after year is just becoming a bigger issue here at the Global Conference. It's great to see so many global health leaders that are here today. And I want to just share two quick little anecdotes that help me think about the issue we're going to get into. One is, I remember during COVID, speaking to somebody who is actually in the building today. He is a prominent Nigerian businessperson. And he said, "We often thought, me and the folks like me, that if we had a health issue, we could get on a private plane, and we could fly to Europe, and we'd be fine. And so we didn't worry quite as much as maybe we should have about the quality of the health infrastructure around us." And then when COVID hit, couldn't fly. Right? It didn't matter how wealthy you were. You were only as safe as the health infrastructure around where you live, wherever you were in the world. And that was a real eye-opener for him and for many other people, I think, including many at this event. And then recently, you all know how much foreign assistance has been cut. USAID is obviously the most prominent. We broke that story at Devex, but so many other countries represented at this event, too, have cut their foreign aid spending, and a lot of that was going to global health. And in fact, we are now down at the point where official development assistance, foreign aid, is lower than when the sustainable development goals were put forward in 2015. So we have kind of erased a long period in which the world said, "Hey, let's get together and fund this stuff." Okay, so what do we do if we have half the world in a position where they don't have access to medical services, if we know that pandemics can come, because I know it seems like a million years ago, but it was pretty recently that our

lives were all changed by one. What do we do? What's the new model? How do we fill some of these gaps in a way that maybe isn't so much about aid, is much more about investment, and it's about partnership. How do we actually stitch all of that together? So that's what we're going to talk about. And we've got a fantastic group to get into that topic. And sitting next to me is Dr. Jean Kaseya, the director general of the Africa CDC. Maybe you can kick us off on this, because to the conversation about aid, Africa was often the recipient place for much of that aid. And now there's a big new conversation happening that you're actually leading on a new way forward for investing in a health system that will be more resilient, that will protect us more from pandemics and other kinds of health risks. Tell us about how you're thinking about this today.

Jean Kaseya 02:58

Yeah. Thank you, Raj. As you said, for more than 60 years—I can say even 80 or 90 years—if we consider when the colonization started, our countries were used to ODA. They didn't start to invest in the health system. They knew that vaccine, medicine, even salaries for health workers will come from somewhere. Then suddenly, ODA cut. And for me, I was talking about it with my leaders. I took it as a huge opportunity. Huge opportunity to change the mindset, to change the model. Look, we have some examples, and even next week, I think I'm releasing a paper in Devex on the Kenyan model. After one year, I started with President Ruto to say, "Let us start to implement the digital transformation agenda." And after one year, we're evaluating that in Nairobi last week. Kenya managed to bring from around 5 percent to 6 percent of people under health insurance scheme to 26 percent. Kenya managed to reduce the fraud in the health system from 27 percent almost to around 5 percent. And Kenya managed to create, with $1 billion investment, the saving of $1.5 billion, and the saving will continue to increase. More importantly, we moved, and today we have around 53 percent of Kenyans under health insurance scheme. What it means, we are not just protecting the system, we are creating the market. Mostly, when I was discussing with CEO of pharma companies, they were telling me, "We are not investing in Africa because there is no market." Now we are creating the market. And this is the model. We'll talk about it, how we are implementing that in other countries.

Raj Kumar 05:09

Right. A lot of the term of art that we often use in the global health space was health system strengthening. And I think the new term a lot of people are talking about now is health systems transformation. So of course, you need a strong health system. But given the move from aid to investment, given artificial intelligence, new technologies, more of an embrace of market-based models, is there an opportunity to do something differently? All that said, we should not undercut the urgency of acting on this, and I want to bring Stephanie Psaki in on that point. You're at Brown University now, where you're a senior fellow, but you were also America's first US coordinator for global health security. So you were thinking about what are the threats that are out there from a US national security perspective, as well as a global health perspective. So many people sort of forgotten about COVID. It feels like it was a different era. What are you thinking about when you, I don't know, maybe open the newspaper today and see that there are people on a cruise ship who've died of a hantavirus, right? How should we understand global health security in this moment?

Stephanie Psaki 06:13

Yeah. Thanks, and I just want to start by commending Dr. Kaseya's leadership in this very difficult year plus, because many of us in the US were still kind of stunned by what was happening. And Dr. Kaseya and African leaders, I think, were moving and adapting to the new reality very quickly. So I think we can all take a page out of that book. We have this shared trauma as a world that should be something that brings us together, which is the COVID pandemic. About 25 million people died, and we would like to all believe that that was a once in a lifetime experience. It was not a once in a lifetime experience for many of us. The odds of another pandemic as bad as COVID or worse in the next 25 years are about 50/50. And that is probably an underestimate because the risk from naturally emerging threats is increasing every year. Africa CDC has published about a 40 percent increase, I think, from 2022 to 2024 in naturally emerging threats. There's a proliferation of labs around the world that are doing research on high-risk pathogens without the appropriate biosafety procedures in place, and the risk of a biological weapons attack is increasing dramatically because of AI dropping the bar in terms of the barrier to entry. So for all of these reasons, 50/50 is probably optimistic. I was going to say 50/50 maybe before AI made it really easy. 50/50 before all of that. Exactly. So it's likely going to happen, and we're not ready.

Raj Kumar 07:49

Yeah. Well, we're going to get into maybe in the conversation what it looks like to get ready. But Kris, maybe I can bring you into the discussion because we're talking about the private sector a lot already. Kris Licht, who runs Reckitt, a company that you may not know the name of, but you certainly know the name of all its products—Lysol and Dettol and Mucinex and many other things that people use for hygiene and for health around the world. As I said earlier—and you heard a little bit from Dr. Jean—the private sector was sometimes squeezed out of this discussion or marginalized into its own pillar. Are you seeing a shift? And where do you think the private sector fits into this idea of a health systems transformation?

Kris Licht 08:28

Yeah, so thanks for that. I think the private sector is absolutely essential if we're going to solve these problems. I know that sometimes there's been considerations around for-profit versus not-for-profit and public sector and certain organizations not wanting to partner that much with corporates. I think that's a mistake because, I actually think that public-private partnerships and market-based solutions is the only real way we're going to get this done. I also think, by the way, that that would generate a lot of economic growth as it's deployed. So at Reckitt, we work with a lot of entrepreneurs, and we fund local entrepreneurs all across Africa, in North America as well, through our Catalyst program. And the whole idea is to support people in the community that have the right ideas, that have the drive and motivation and entrepreneurial energy to go solve a problem, whether it's health care access, whether it's water access, whether it's hygiene and sanitation. If you turn it into a business, it scales faster and people have a vested interest. We have a history of giving a lot, right? A lot of philanthropy corporately. We've worked a lot with schools, with local communities. We've given wells, we've given rainwater collection systems and handwashing stations to schools. And when we give things away, it doesn't sustain.

Raj Kumar 09:58

Right. There's no model for maintenance or training.

Kris Licht 10:02

It's not maintained. No one's really dedicated to making it theirs and making it better and building on it. But if it's someone's business, then it's a livelihood, and then they have a stake in it. And so what we see this when we extend microloans to women in Africa who then actually secure rainwater for their village or their family, then they build a business, then they go to school, then they send their kids to school. Lots of things happen from fairly small catalytic investments.

Raj Kumar 10:31

Yeah. And some of those investments, small and catalytic, could even come from philanthropy, even in a market-based model. And maybe Judy, I can bring you in on that, too, the role of philanthropy here. Judy Monroe is the president and CEO of the CDC Foundation. You've run that for about a decade. Before that, you were the number two at CDC itself. Of course, CDC has been cut a lot. WHO has been cut a lot. So the architecture is shifting in part because there's no choice, given all these agencies and institutions that used to do a lot of what's in the title of this session are shrinking. So where does philanthropy help to fill some of that gap, if at all?

Judy Monroe 11:07

Yeah, no, philanthropy can play a huge role. First being catalytic, and taking the risk. And we heard about that, there was a great panel earlier today talking about the role of philanthropy. If I go back, so we were, as an example, during COVID, we leaned in really hard at the CDC Foundation on our fundraising because we're not a DAO. We had a lot of donors come forth, and that funding, we were able to deploy really strategically, and much of that was philanthropic. And so speed matters when you're talking about the actual outbreak, and philanthropy can play a role there. But we need to build the systems that have that funding ready to go for the outbreak, and you've got to build that infrastructure that we know what needs to happen, right? So speed matters because the faster that you identify the new pathogen, or the first case, which sometimes comes from community health workers, that front line, the astute person that knows what to recognize. That happened with Marburg, in Africa not too long ago. It kind of stopped the disease in its track. But if you don't have that infrastructure, you've got a huge economic burden there. But philanthropy to me needs to be unlocked. We also heard this morning there's a lot of philanthropic dollars on the sidelines. But it needs to be done strategically along with the public-private partnership. So I think it's federal, it's funding, and countries may need to bump up, and then there's philanthropy and then there's private sector, and let's design that for the future.

Raj Kumar 12:39

And obviously you have the Gates Foundations of the world, $9 billion a year. It's a massive entity in its own right, but there's so much other philanthropy that's smaller scale, and people want to make an impact on health. They're off there doing one little thing here, one little thing there. How do you stitch it together into more of a marketplace where the best ideas bubble up? And then Kris, you wanted to jump in on that point?

Kris Licht 12:59

Yeah, I think you're right that we suffer from fragmentation. So, water access, I spoke briefly about it. This is something we're very invested in because way too many people—around two billion people—don't have reliable access to clean and safe water. And by the way, when you solve that problem, you solve a lot of other problems because all of a sudden the mother in the family who typically is collecting the rainwater has time to take care of her kids, or educate herself, or run a business. The kids go to school. They're not helping her. So solving something like water is something that's really important for us, but there is fragmentation in this landscape. And one of the things I'm a big advocate of is we go together. We have to have platforms where we pool our resources, both in the non-profit world, which I think is very fragmented on many of these issues, but also in terms of corporates. I don't want us at Reckitt to just have our own initiative. I actually want to go together with others. And so some of the things we're doing is we're trying to pool our resources and use our balance sheet along with other big corporations to create asset managers that can actually deploy that capital in a way that's at a totally different scale than if we were trying to do it ourselves. So I think it is very important in a time of need, in a time of limited resources, that we all commit to scaling and doing it together, as opposed to doing our own little thing.

Raj Kumar 14:25

Yeah, a lot of that, I think, starts with having the right government partner. If the country has their own national strategy for health, if they have a clear plan, as you're saying, in Kenya, you've been working with President Ruto there. If there's a clear plan, then the market can, whether you're not-for-profit or for-profit, you kind of know what to engage with. I guess, Stephanie, I wonder, you've laid it out pretty clearly how serious the challenge is. Any minute now, we could face that next pandemic. And we're talking about, okay, we're going to enter this new world where there isn't really the aid money that there was before to set up some of the surveillance systems of frontline health care workers that there were just a few years ago. So how do we fill that gap? Is there a market solution to this problem, or how do you see it?

Stephanie Psaki 15:10

Well, I think it's important to just start with the cost-benefit here, which is probably intuitively obvious to everyone. But the estimated cost in the US alone of the COVID pandemic was $16 trillion. So anything

that costs less than $16 trillion will be a good investment. But actually, the estimates are that an influenza pandemic would be much, much more deadly and much more costly. So just starting from, I think, something that seems obvious, which is that prevention is going to be more effective and less expensive than having to respond to a pandemic, which, as I said, is very likely to happen. So the problem is there is money for that. The DOD budget for the Department of Defense is about a trillion dollars annually. The proposed budget from the Trump administration is increasing that budget by 50 percent. You could take a chunk of that budget, and the US government could pay for this all out. I don't think that that's the solution, though, for the reasons that we're discussing, because then the system is very dependent on donor dollars. So the big question is how do we build a system that is not top-down, that is not driven by one donor or set of donors, that is driven by the local markets? And I think there is a lot of really interesting work—just as an example, that the DFIs have been doing, the development finance institutions, and I think are hoping to launch a new opportunity at UNGA this year to create capital to build manufacturing at a smaller scale, initially in the Africa region, that then can be scaled up. Because the only way we're going to be able to respond quickly in an emergency—we have to invest in the R&D, we have to have the product, but we have to manufacture enough of the product for the entire world. And right now, we don't have the capacity to do that in the United States, and we don't have the capacity to do that around the world.

Raj Kumar 16:58

And that's also how you make global health and African health investable, right, Dr. Jean? I mean, the idea that you're going to just do primary health care, but you're going to have to ship in the drugs from overseas or all of the medical devices from overseas—you don't really have enough of a domestic market then to create the investment. You need to find ways to make this an economic as well as a national security objective. Even though there might be some inefficiencies in the short run, might be cheaper to buy the drugs from a generic manufacturer in India or Brazil. How are you seeing this idea of turning African health from a need to an investment opportunity?

Jean Kaseya 17:36

Look, currently we are talking about 1.4 billion people. It will be 2.5 billion in the next 15 years. It will be the biggest market in the world. But why are we calling Africa not a market? Because currently, we are working with around 7 to 10 percent. Why I'm talking about 7 to 10 percent? A country like Nigeria, the informal sector is representing 92 percent of people. This is a country of 200 million people. It means when you go to invest in Nigeria for the health sector, only 8 percent have access to health insurance that they can afford what you are bringing. Now, what we are doing is just amazing. And I'm saying to people what minister for Germany was telling me a week ago: If you don't invest in Africa today, it's like you are missing to invest in Asia 20 years ago, because now we are creating this market. With the digital transformation agenda, we are identifying people, we are helping them to come to get access to the system, through the health insurance, like what we did in Kenya, but we already did it in Rwanda and other countries. That market will then expand. Kris and other private sectors, they will find a way to come to make more money because they know that Africa will be the next Asia in the next few years. That is the most important concept that we have today, and that will give also added value, as Stephanie's saying,

how all of them can come to work under the leadership of the government for one plan. Because if we are not aligned under the leadership of the government, and if we continue to work, you can bring $200 billion as philanthropy, you will not resolve issues in Africa. If we don't create this market and if we don't create alignment, these are our two major topics, and we are making success on that.

Raj Kumar 19:45

Kris, does that resonate with you? Some of these are big markets like Nigeria. But a lot of these are countries that are much smaller, very small economies, a lot of challenges. Do you still see this kind of optimistic view that this is an investable market for you?

Kris Licht 20:00

Yeah. So, we operate in much of Africa and obviously centered in the big markets, have local production, actually, make health and hygiene products locally. I think it is critical that this sector grows and that it's set up for success. I think there's good things happening in terms of countries trying to create more environments, more conducive to investment and growth. But I also note that some of our competitors have not done so well, and some have left the continent altogether. We're not going to do that because, a), it's a big commercial opportunity, and b), we actually want to put better health in more hands. So we want to be there, and we want to contribute. We feel an obligation to also do that. So for us, it's not really a distinction between trying to solve these health outcomes for a need as much as it's opportunity and needs. The same thing. We want to solve the problem. We want to put health and hygiene and sanitation and make it widely available, right, and to secure that access. That's going to make communities thrive, it's going to drive economic growth, and eventually, it's going to help more people enter a sort of middle-class type existence where they can participate more fully in all the medicines that we take for granted.

Raj Kumar 21:15

You do have an advantage, of course, which is that you're selling a lot of products that even retail can buy. The average consumer can buy it. I think where you've got challenges for a lot of the medical device and pharmaceutical companies that come to something like Milken is when there isn't a clear government plan, when very few people are part of a national health insurance system. Who do you sell to? The hospitals don't have enough money, there isn't a clear market to sell into, and those can be really challenging to get the flywheel moving.

Kris Licht 21:44

I think that's right. I think we have to build it layer by layer. What I'm talking about is so basic. Access to a health care professional in your community, access to water, access to a functioning toilet. We have to

solve those problems. I acknowledge that there's other, maybe trickier problems to solve for certain parts of the health care ecosystem, but let's solve the basic ones first. There's a tremendous need.

Raj Kumar 22:09

Yeah. I agree. I want to hear what you have to say on this, Judy, but I also just want to warn everybody, I'd love to get your questions or thoughts, too. So there is a QR code that's been around. You can put them in that way. I'll also just come to you. You can raise your hand in a minute and share any thoughts or ideas you've got. Yeah, Judy, what's your take on this evolving discussion?

Judy Monroe 22:29

Yeah. A few thoughts. And certainly, sanitation and water, all of those are really important. But we know that you've got to have the system in place for the laboratory capacity across the communities. You've got to have epidemiology. A great program that CDC has had is FETP. It's a field epidemiology training program. It's been around the world. It's highly successful. You've got to have that expertise and have that infrastructure. The question I would have, in terms of thinking about funding, and I do love private sector investment and where that might go. If we as a globe and all the large companies, the international companies, would come in and view it more as insurance. Because you mentioned $16 trillion. That doesn't count all the outbreaks that are billion dollars, right? So there is a true economic hit anytime that you're getting these outbreaks at different scales. And so, if you do the math, I was playing with the math a little bit. It's really very reasonable if companies would come in and maybe there's a pooled source, and it's more of an insurance plan. We insure against hurricanes, we insure against other threats. Cybersecurity, people are interested in. This is protection.

Raj Kumar 23:49

I think it's one of those tragedy of the commons problems, though, right? Because it is an insurance issue, but politically, it's hard to convince taxpayers—

Judy Monroe 23:56

Exactly.

Raj Kumar 23:57

—pay for it now, something bad might happen in the coming years, or to tell corporates, "Invest in this, it's going to be in the long term better."

Judy Monroe 24:03

And then we have the boom and bust—

Raj Kumar 24:06

Right.

Judy Monroe 24:06

—and then in the end, we're paying more money for losing lives.

Raj Kumar 24:10

Exactly. Yeah, and you wonder, how do you get out of that? Okay, I'm going to pose one more question to all of you, and then looking for questions through the QR code or from the people in the room, which is we heard, Stephanie, from you about AI as a negative so far—very real scenario, and there's some recent reporting on this—that you can use some of these tools, and they will advise you on how to build a superbug that can lead to a global pandemic. But what about the upsides here? Because it seems like some of the things Judy just mentioned—community health workers, diagnostics—it seems like there's got to be some places where AI is going to be able to revolutionize this space. How are you seeing it?

Stephanie Psaki 24:48

Yeah. To come back to what I was thinking about all the time when I was at the White House, it is just three steps: stop a new threat from emerging, stop it before it spreads, or make sure you have countermeasures to contain it. And it's cycling through that every single time, no matter what the scale of the threat is. So AI can help with every single stage. And I was just thinking as you were talking about this tragedy of the commons, that biosurveillance is an area where there, I would think, is enormous benefit to the private sector of having a much more comprehensive global biosurveillance system. We're aware of all of the pushback in terms of the politics and the ethics of that even, but having a global biosurveillance system would be incredibly valuable in terms of detecting emerging threats, whether it's a biological weapon, a naturally emerging threat, or a lab leak, and responding quickly. It would also be very helpful for pharmaceutical companies and biotech companies to be identifying potential emerging threats and developing products earlier on so they're ready to go. So to me, that is a global public good. The cost of it in terms of what the benefits would be is minimal, and I could see there being private sector actors who could help take advantage of that.

Raj Kumar 26:03

Mm-hmm. Yeah, I see you nodding, Kris. You feel like there's a business opportunity?

Kris Licht 26:07

Yeah, I think many of us are interested in that and for I think many different reasons. But I think prevention, early detection, it's got to be a place where we collectively find better solutions because we know the next pandemic is going to come. The science is pretty clear.

Raj Kumar 26:26

All right. I'm looking out to the audience to see if we have any hands. Anyone who wants to share something? I got a bunch more questions I can pose to these folks, but in case there's a burning one... All right, I'm going to come back to you. I'll give you another minute to let it settle. Go ahead, Dr. Jean.

Jean Kaseya 26:39

If I have to say something, in my village, people didn't have landline. We moved from nothing to 4G. And I have to say, in Africa, we are accelerating the process, and AI for us is a major opportunity. But before talking about AI, we need to talk about connectivity. Currently, the connectivity rate in Africa is still low. This is why I'm signing even MOU with Starlink to provide connectivity in African countries. I'm like Lee Kuan in Singapore. I don't have ideology. I don't have nationalism. I'm realistic. If I can find solution somewhere for connectivity, I will bring that to Africa. And this is what we are doing. And you can see now with this MOU we are signing, bringing internet, bringing AI, Africa will make a big jump. And that one, we are linking that with this health insurance scheme. You can imagine 50 percent of people in Africa today, they have a mobile phone. But only 10 percent have health insurance. And these people, they are paying $36 per month to fill their mobile phone. You can imagine if we say $1 plus just for the health insurance. These kind of ideas—I think we'll discuss that more. We have a clear way to move forward, and this is why even I recruited someone who did great job in Botswana, a special advisor to the president of Botswana, because Botswana is one of the countries well-connected in Africa. He's become my senior advisor in Africa CDC to implement this model in Africa.

Raj Kumar 28:39

So we did get one question in from the QR code—feel free to put more in as well—about the global health risks we're not paying attention to right now that we should be. So I open that to any of you, and in particular, I'd love to get your take, Stephanie, on this very early emerging case on a cruise ship. But is that something that worries you, this hantavirus case we're seeing in Cape Verde? What should we know about that? How worried should we be?

Stephanie Psaki 29:05

Yeah. So for people who are not tracking this and not on many text chains about the hantavirus outbreak, which I am, unfortunately, there are about 150 people, give or take a few, who were on a cruise ship for the last few weeks. They traveled to a bunch of different countries. They started in Argentina. There have been three deaths. One of them was confirmed from hantavirus, which is a virus that is spread from rat feces and urine. And the one strain of hantavirus that sometimes has been identified in Argentina has also shown the ability to be transmitted from one person to another person. So, there are two other people—I think three people have died, and there are three other people who are hospitalized, and the remaining 150 people are stuck on the cruise ship right now. So, when I read that, part of what strikes me is the first person died on April 11th. We are still trying to confirm whether the other people who are sick are sick with hantavirus. We—as far as I know—don't have therapeutics that are being provided to those three people or to others who are on the ship. We should be able to—as soon as the person got sick in early April—figure out what was wrong with them, treat them, figure out what therapeutic is needed, get the therapeutic to them, avoid any deaths, and make sure that people don't have to be stuck on a cruise ship. The fact that we can't do that with a known threat—and this is similar to what we're seeing with measles—the fact that we cannot do this collectively—and this is not any individual country's failure at this point—is a flashing bright light that we are not ready to respond to a newly emerging threat that could be much more serious than the COVID pandemic.

Raj Kumar 30:55

Yeah. I want to hear from a few of you on this. Go ahead, Judy. Because I know WHO did send a team onto the ship, and we don't just have to talk about the hantavirus case here, but just more broadly, what does it say, given that WHO has had their funding cut so severely—CDC as well—what does it say about the infrastructure that's out there right now?

Judy Monroe 31:16

Yeah. It's been weakened. There's no question. And it's urgent that we strengthen it and we rebuild what we have and strengthen it. When you think about what's next and what we need to be worried about, One Health is the concept. So it's human health and it's animal, and it's environmental. Tropical diseases are no longer in what we thought of tropical. We were just talking about dengue. Singapore had a lot of dengue and learned a lot from dengue. Now Germany is asking Singapore to help them understand and manage dengue. It's in Germany. Who would've heard of that? So you've got the threat of diseases emerging where they've never been before. So it doesn't have to be a new disease, but it's in a new place. And then you've got the viruses and the bacteria change, and when they jump from animal to human, we don't know which one's going to do that next and be the next pandemic. That's where it all comes from.

Raj Kumar 32:14

I wonder, Dr. Jean, if you have a word you want to say about this situation, because a lot of it is in Africa right now. I think one of the deaths happened in South Africa. The boat is in Cape Verde right now, from what—the latest I understand. What do you know about the case, and is there anything you want to share publicly about it?

Jean Kaseya 32:32

Yeah. I think as Judy said, currently we need a strong collaboration, but we need also to own this program. Look, you'll see in my LinkedIn today—or X—I released an advisory committee on the human genomics in Africa. Why we are doing that? Because we want to contribute on the research. If you see, the continent where we don't really do the human genomics is Africa. And we don't have an idea of what is happening there. And drugs we are using, all medicines we are using, it's based on studies conducted from other continent. And we can also contribute, and we are also willing to share data and pathogens. We have no problem because currently we are negotiating the PABS, pathogen access benefit sharing, with WHO, and it will be discussed in Geneva. What we are seeing clearly—yes, cutting fund to WHO, to the CDC, to other organizations, yes, we are losing opportunities to strengthen the system, but we need also to find other ways to continue to work and to make the system more solid with some of the initiatives we are bringing.

Raj Kumar 33:56

Yeah. The old model may be where WHO had to kind of take over everything because countries had very weak systems, or CDC—your predecessor was paid for through the CDC, the US CDC, right? So that may be not the most sustainable model. And we need new models and agencies like yours that can grow up and have their own sources of funding and take on some of this responsibility.

Jean Kaseya 34:18

And this is absolutely true. Let us be honest. What was the model that Western countries, they were teaching African countries for a very long time? First, health is social sector. It means you cannot create money for your health. Second, we cannot transform patients to consumers. And this model led African countries to be where we are today. Now, what Africa CDC is saying, you made it. My salary is paid by African member state. Second, we are transforming the patients to become consumers. Because when that person become consumer, the market is there. This is why people like Kris, pharma companies, and others, they will come to invest. And third, we are now making African countries driving and leading the health sector, telling them that in the US, 18 percent to 20 percent of the GDP is coming from the health sector. In Africa, it's still 5 percent because we didn't mature that system. Now we are maturing the system to increase the GDP coming from the health sector. And you'll see in the next 10 years, the face of Africa will radically change because of some initiatives that we are taking, and we are giving responsibility to countries.

Raj Kumar 35:49

Kris, did you want to jump in on this conversation?

Kris Licht 35:51

No, I agree with that. I actually just had the reflection. We're talking about issues that are very urgent in Africa, but actually the discussion we're having about prevention, about threat detection, and investing a lot more with technology in those areas is universally needed. It's needed. I live in the UK. It's needed in the UK. It's needed in the US. Actually, these are opportunities that are very broad. So not to in any way take away from the urgent need in Africa, but actually preventative care and self-care as the first way of avoiding people getting sick or extending the time that they don't become patients, that's actually the big opportunity for lots of health care systems around the world.

Raj Kumar 36:37

And they're moving in that direction already. You tell me. My sense is people are voting with their feet, in a way. They're wearing wearables. The number of people here at Milken with a wearable on of some kind, they're monitoring their own health, they're getting information. Now, maybe the sources of that information might be questionable sometimes, but they're going out on the web and getting information on their own and trying to take more control over their own health. It seems like there is a pretty big shift in that direction happening now.

Kris Licht 37:04

There is. Yeah, we can see that clearly in our consumer research and data. I think COVID actually did elevate everyone's awareness of two things, that hygiene is the foundation of good health, and that at the end of the day, your health is very much up to you. It's what you do with it, and if you take control of it, and try to shape it and improve it, that you have better odds when something very bad happens, like it probably will happen again. So, I think this move towards self-care and preventative care is the way that we need to go, and we need to build businesses around all that. So we have a self-care company, but we need more frontline care, and I think a more private model of that will be more sustainable, but we can have all kinds of different models. But frontline care, diagnostics, using these tools in any—whether it's a village in Africa that gets connectivity and then you can do it, or whether it's in lots of communities in the US. It's the same need.

Raj Kumar 38:07

I assume this is true, but you have the data. During COVID, obviously everybody started using Lysol and Dettol hand sanitizer products, all that. I'm sure it spiked. But it's come back down, but I assume it's at a much higher level than what it was before.

Kris Licht 38:21

It is at a higher level, and I think that's a positive. I think for a while, maybe people went a little overboard. I heard about people using Lysol to clean things that maybe didn't need to be cleaned.

Raj Kumar 38:32

Our household were briefly one of those people.

Kris Licht 38:34

Yeah. Right. So I think there was a bit of understandable panic and wanting to be safe. But actually, yes, those levels have settled at a much higher level. And I think that's a good thing.

Raj Kumar 38:44

That's great. All right. I think we have maybe one, two... Okay, a few questions have come in. That's great. Yeah, and I'll just ask you if you can just tell us who you are. And believe it or not, we're running out of time a little, so keep it relatively brief. That would be great. And we'll try to get all the questions in at once.

Steve Anderson 38:57

I'll try to. I'm Steve Anderson, CEO of NACDS, the National Association of Chain Drug Stores, representing the pharmacies. And my question—one, we gave 350 million COVID shots in our pharmacies. But back to your earlier discussion about WHO, with the diminishment of the WHO, and since you're all experts on what's happening on the ground, what does it do for the central operating system of those impacted in the countries that we're talking about?

Raj Kumar 39:24

Okay. Great question.

Steve Anderson 39:25

Not just a political question necessarily, but the real-world impact.

Raj Kumar 39:27

Yeah. Great question. All right, if we can bring the mic over here, we'll take both of yours, and then we'll come back to the panel who can address all of these.

Kelly Gebo 39:38

Good afternoon. I'm Kelly Gebo, the dean of the Milken School of Public Health. And trying to get our students and junior faculty really into public health, particularly global health, and given the issues we're facing with funding, how would you message that to both students and parents who have concerns about the future of where global health is going to go for potentially investing in their children's future?

Raj Kumar 40:01

Great question. Pass the mic. Right behind you. Yep. We'll take one more.

Lynn Goldman 40:05

Former dean of that school and now one of Kelly's faculty members. Lynn Goldman. Hi. So actually, my question connects more with the question that came from NACDS, which is it feels to me like even during COVID, kind of the central nervous system of public health that we'd like to see for surveillance and for awareness and rapid response to pandemics wasn't perfect during COVID, right? And there were endless efforts to figure out how to make it better, and instead, it's been made worse. And I realize things are improving on the ground in many countries that are developing and bringing more resources to bear on health. But the value of rapid identification of epidemics, of rapid data sharing, the ability to quickly communicate and act. I think the example of the hantavirus on the cruise ship is a great example of how that is not even better than before COVID, but worse. And I'd like to hear how do we move forward with that? Obviously, going back to the past, to me, wouldn't be the right thing to do. We all felt it wasn't perfect before.

Raj Kumar 41:20

Yeah. That's a great series of questions. We'll get to all of them. Maybe Judy, we can start with Lynn's question. Yeah, it does seem like we know what we need. Certainly, during COVID, it was made very plain

what we need, and yet it's maybe worse today? Do you agree with that characterization, our ability to surveil and rapidly respond is actually worse than it was?

Judy Monroe 41:41

Well, we've lost workforce. For starters, there's been a diminishing—That's the highest cost is always going to be personnel. And so one of the first things to go when you get cuts are the people. So yes, that's cornerstone. And the urgency is to unlock the funding. I wanted to respond. We need the best and brightest in public health. And so going back to, all of this ties together, so if we've lost workforce, and then you don't have students wanting to come in, or we've got folks, very seasoned people at CDC that now have gone on to open bake shops and things like that because they lost their jobs. So bringing that back is going to be super important, and I think it's incumbent on all of us to unlock those resources as we've talked about today. So whether that's private sector, more government funding, whether it's philanthropic support, philanthropy can be the catalyst and needs to be the catalyst to lead the way so that you can have the private sector solutions. I think all of it has to come together. But yeah.

Raj Kumar 42:42

Yeah, Stephanie, maybe you could just follow up on that same point. If we've weakened our ability to know what's happening around the world, right? Where there's an outbreak here or there popping up, we don't have the teams that we used to have to go in and respond. Steve asked, "What does it mean in the real world practically that WHO has been diminished so much?" How do you look at that? Because we're talking in a way, a little bit of happy talk about the market solution, it's all going to get better if we can design this new era. But in the meantime, we've lost a lot of this capability. Have we not? Or how would you address Steve's question about what directly have we lost?

Stephanie Psaki 43:20

Yeah. Well, I can answer it from a US national security perspective, and I'm sure Dr. Kaseya can tell us on the ground what it looks like right now. As Judy said, our eyes and ears, the way that we knew when a threat was emerging was not just the staff that were on the ground all over the world through USAID and through CDC, but because of the relationships that they had built with health workers in the communities, with the ministries of health. This is not theoretical. They would get a phone call that said, "There's something strange going on in this community. Go check it out." And we often knew that it was happening days, sometimes weeks before it was public, sometimes before WHO knew. I don't know if it was before Africa CDC. And that meant that we could take a look at whether we had a stockpile of countermeasures that were effective against that threat. We could immediately send diagnostics and treatments and vaccines, if they existed, to the site to help contain the threat, and we could work in partnership. We don't have those people doing that. At the same time, and this is what I say to students in global health, there is an opportunity right now to shape the future of the field that we have not seen since probably 2000, the early 2000s, the beginning of the AIDS pandemic when PEPFAR was launched and the Global Fund and all of these other institutions were launched. That created a field that we all have gotten very used to for the

last 25 years that either has been destroyed or weakened or is going to change in the future. So for the generation of global health students, there is an opportunity in this gap to create something that works better. It should not be true that we have to fly someone from CDC in Atlanta to DRC to help contain a threat. That's not a sustainable system going forward. So what is the new version of it that we're going to build that works better?

Raj Kumar 45:15

Dr. Jean, go ahead.

Jean Kaseya 45:18

Stephanie knows why she said that, because she knows that I will support that. This model, the whole model of having people flying from Atlanta, from Geneva to Africa, it's over. Look, I come from South Sudan. That country before, it's a country facing a lot of challenges: insecurity, vulnerability of population. But Africa CDC managed to support the country to have capacity to do genomic sequencing. Last week, we had an alert of hemorrhagic fever. I got this message on Friday. Because we already empowered the country, on Monday, they collected the sample, on Tuesday, they had the result that it was negative. In the past, they had to wait for someone coming from Geneva, going in the field, collecting data, bringing this data back to Europe for the testing, and having the result maybe after one month. This is not the model we need. And yes, the new generation of global health leaders, especially in Africa, we are training them. This field epidemiologic program that we have, we are training around 1,000 epidemiologists in Africa on yearly basis. And all countries today, if you see, are growing in Africa in terms of genomic sequencing capacity, in terms of surveillance. Yes, I have to acknowledge decreasing funding is decreasing some of the capacity we wanted to increase for countries. But we need to adapt. We need to adapt with what we have. A country like Burundi, they have only one lab. In the past 12 months, we managed to bring that from one to 42. All regions are covered. It means when you have an outbreak, quickly now in Burundi, they can provide the result. I think we are moving, but there are still a lot to be done, and clearly, we are seeing the model of exporting people from US, from Europe to Africa is over.

Raj Kumar 47:35

Let me just ask you one quick follow-up on that, because we heard from Stephanie earlier that biosurveillance should be an area where there's private sector interest. In theory, there should be a market. There are these global health compacts that the US government has put forward. You've been in the middle of this, working with the Trump administration, working with your member countries in the African Union. And one of the provisions, controversially, is that the US would get access to some of the information that it sounds like Stephanie's saying we used to get informally as well as formally in the past. This may be everybody benefits in a way, but we're still stuck a little bit, to Lynn's point, in terms of what's happening today. Who's writing the check? They might sign the health compact. Who's actually going to go out and do the surveillance?

Jean Kaseya 48:22

Look, I was talking with Zimbabwe and South Sudan last week because these are countries still negotiating, and I was discussing with a number of countries about this data-sharing agreement. We in Africa CDC, we have data-sharing agreement with all African countries. They are sending us data, and we are sharing this data to neighboring countries when there is a problem. But from the US side, and this is the conversation I involved with our colleagues, we say, let us sit together. And I think we are just finding a time to have a meeting, State Department and all African ministers, to discuss this issue, data-sharing agreement and pathogen sharing agreement. I think we'll get there, but the main message is the ownership of data is sitting with African countries. They are giving opportunity to share some of the data related to the program they have with the US, as they can do with other partners. But that one is not negotiable. For MOUs where I managed to support countries, I made sure that it's written, the ownership of data stays with African countries.

Raj Kumar 49:36

Stays with the countries. Obviously, there's a sovereignty question there. Maybe, Kris, I can come to you for Kelly's question about—what do you say to parents who are wondering about footing the bill for a graduate degree in a master's in public health? Here you are telling us this is a very fast-changing world. And it's going to be more about other kinds of skill sets and other kinds of industries that are connected to global health. What would you want your own kids to study if they wanted a career in this space? Or is there still going to be room for as many MPHs as we have today?

Kris Licht 50:13

Yeah. I think maybe the curriculum needs to evolve a bit to match this current reality. I think maybe the form of these careers will look a little different, but I think there's no question about the need. There's no question that you can have massive impact if this is your chosen career, and if my kids wanted to do that, I would wholeheartedly support them. And I think you just have to be more interdisciplinary in our thinking. We need public-private partnerships. We need to turn some of these things into investable assets and business. We should not be shy about that. That's not a bad thing. It's a good thing. It makes it more durable and sustainable. And if it creates economic growth in these countries at the same time, well, isn't that just wonderful that that would come on top? So I think if we think about a career in public health as purely the traditional career path in the old environment, then I think maybe we're missing a trick. I think we need a whole generation of young leaders that can navigate across the silos and actually solve the problems, right? I love what you described in terms of the pragmatic approach. Let's not be ideological about it. Let's not be worried about these legacy norms that we've had. Let's just go solve problems. And we need young people that can think like that.

Raj Kumar 51:39

Yeah, I've been in so many sessions where someone will say, "I'm a global health expert. I'm a leader." But let's talk to that person there, the tech expert, or that person's the finance expert, and actually, you need to know all three of those things. That's when you're really able to have an impact, when you can bridge across. It seems like we are in a moment now, if you are going to turn this into more of a public-private market, make global health investable, those skill sets become really important. What's your thought about the skills, Judy, that the future—

Judy Monroe 52:09

Well, no, I couldn't agree more. And there are plenty of folks that have trained in public health that work in private sector. More and more, we see private sector hiring folks with the public health skills. So I think that is the direction of the future, is having all of that systems view and having people that understand public health, but understand the others and can really apply it. Super important.

Raj Kumar 52:32

Stephanie, you have a thought about that? The skills that are going to be needed in this new era?

Stephanie Psaki 52:36

Well, I'm just thinking, we will have to rebuild the loss in the government at some point, in my view, for the US government to be effective. And it is very difficult for people who come from a public health background, spent most of their career working at CDC or working at USAID, to get jobs in the private sector. So I wonder if there's an opportunity to create more space for rotations from people from the private sector into government, and also from government into the private sector, even in the short term, to learn more. Because I think within government, there is a real lack of even the language to use to engage effectively with the private sector, and if this is where we're headed, we need to be able to speak the same language to each other.

Raj Kumar 53:20

Yeah, and it does seem to me, even if we do rebuild some of this capability inside governments in the Global North, there are probably fewer jobs, right, in the future. Partly to the point of Dr. Jean, that we're not going to be building these capabilities in Geneva and London and Washington to the same degree that they were built in the past. There may be some happy medium there, but presumably, a lot of students who graduate from your program are going to need to find roles that are either in the private sector or closer to the ground to where the problems and the gaps really are in the world. Yeah. Does that make sense?

Judy Monroe 53:56

Yeah.

Raj Kumar 53:57

Listen, we're just about out of time. I'm going to give you, Dr. Jean, just a last word here. Because we are in this unique moment where Africa is not just at the table, but in many ways is leading the conversation. You have the Accra Reset, you have yourself and many of your colleagues who are saying, "We're going to set the agenda for where health goes in Africa, and then we're going to invite others in." But the agenda is not being set anymore in global capitals the way it was. How do you see this precise moment that we're in right now?

Jean Kaseya 54:30

It's exciting moment. Exciting moment first because our government understand that money is sitting with the private sector. Then we need to create conducive environment for them to invest in the health sector and to create more value. Second, it's because we have a very young population. They are looking to use opportunity of innovation, technology, to be also involved. And that one is a major opportunity for us to reach, as we are talking about primary health care, to reach mothers and children to provide information. Third, it's a wonderful moment because government, they understand that health sector is their responsibility. They need to start to invest in the health sector before talking with partners. I think this message today in Africa is resonating under what we call the Africa Health Security and Sovereignty Agenda. That is helping now to see how Africa is bridging with other partners and continent to make the world safe.

Raj Kumar 55:33

Well, thank you very much. Listen, I just want to say, this is a fast-moving space, so if you are interested in what's happening in this space, obviously follow the story of that cruise ship and those 450 people on it. Follow the story out of Washington, these global health compacts, out of Geneva in just another week or two, the World Health Assembly, where a lot of these conversations are going to happen. This is a moment that we're going to look back on and remember, because I think the new architecture of global health is being shaped right now, including by these fantastic people on stage today. So please join me in thanking them for this great discussion.

Raj Kumar 56:09

Thank you so much.

Announcer 56:11

We hope you enjoyed the discussion. Please make your way to your next session.

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